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Programme Committee
1990 session

FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Democratic Yemen

The Executive Director recommends that the Executive Board approve an amount of $5,500,000 from general resources, subject to the availability of funds, and an amount of $5,463,000 in supplementary funds, subject to the availability of specific-purpose contributions, for the country programme of Democratic Yemen for the period 1990 to 1995.

* In order to meet documentation deadlines, this document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme co-operation at the end of 1989, will be contained in the "Summary of 1990 recommendations for general resources and supplementary funding programmes" (E/ICEF/1990/P/L.1).

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THE SITUATION OF CHILDREN AND WOMEN

1. Democratic Yemen covers 333,000 square kilometres in the south-west corner of the Arabian Peninsula. The scarcity of water and arable land, combined with a harsh climate, has confined agriculture to less than 1 per cent of the total land area, concentrated in narrow strips of dry river valleys (wadis) or in the highlands bordering Yemen. Virtually all lands are dependent on spate or well irrigation.

2. The resource-poor country is considered one of the least developed in the world, with a per capita gross national product (GNP) of about $420. Emigrés remittances constitute a major source of foreign exchange earnings. The 1,400 kilometre coastline contains one of the Arabian Sea's richest fishing grounds, but commercial fishing has yet to be well exploited. The recent discovery of oil deposits has raised hopes of alleviating chronic financial constraints.

3. The population of 2.3 million is concentrated along coastal areas and in the wadis and is growing at a rate of 3.1 per cent per year. Its urban/rural distribution is 36/54 per cent, and 10 per cent of the population are nomads. An estimated 20 per cent live below the poverty line. Some 43 per cent of the total population are children below 16 years of age, with infants below 1 year of age representing 4 per cent.

4. Since the mid-1980s, the country has been confronted by a difficult economic situation. Civil strife in January 1986 seriously affected the production sector. Private transfers of foreign exchange from Yemeni workers abroad dropped from $501 million in 1984 to $300 million in 1987, as the entire Persian Gulf region entered a period of recession. Official grants and loans from Arab countries also declined from $269 million annually in 1982-1983 to about $192 million in 1985-1987.

5. As a result, the Government cut domestic demand by reducing imports and development expenditures. Wages and salaries in the public sector were frozen and taxes were raised, although the prices of essential consumer goods, rents and utilities remained stable. Social services were maintained and raises were given to teachers and health staff in 1988. The Government has thus attempted to balance fiscal austerity measures with policies to protect the poor and ensure social equity.

6. While free basic social services have been considerably expanded in the last two decades, the planning, management and monitoring of social services are still weak and constitute major constraints. The network of primary health care (PHC) structures serves 65 per cent of the country and is being expanded further. Although essential drugs are also free of charge, actual utilization of health facilities remains low. Rural areas suffer particularly from the lack of community-based social services and have relatively high infant mortality rates (IMRs) and under-five mortality rates (U5MRs). The population living in very remote and inaccessible areas, particularly the nomads and the islanders of Socotra, are especially disadvantaged and underserved.

7. IMR is presently estimated at 118 per 1,000 live births and U5MR at 197 per 1,000 live births. Communicable diseases, acute respiratory infections (ARI), diarrhoeal diseases, malaria, perinatal problems and malnutrition are the leading causes of death. Underlying and complicating factors include poor environment, inadequate or unsafe drinking water, poor sanitation facilities and poor hygiene.

8. The maternal mortality rate (MMR) is estimated at 100 per 100,000 live births; 73 per cent of these deaths are found among rural women and 92 per cent are due to direct obstetric causes complicated by malnutrition, multiparity and short birth spacing. Inadequate coverage by antenatal care services (varying from 50 per cent in Aden to 7 per cent in Mahra Governorate) and a high percentage of home deliveries unattended by trained health workers further aggravate the risks for women of child-bearing age.

9. Malnutrition is considered one of the most serious underlying health problems of children in Democratic Yemen. A 1984 study showed that 40 per cent of children were affected by malnutrition and 3 per cent had combined forms of stunting and wasting. Severe malnutrition among children varied as follows: 3 per cent in urban areas, 7.8 per cent in slum areas and 6.5 per cent in rural areas. The higher levels of malnutrition in slum districts are attributed to very low family income and the lack of other basic necessities. Incidences of diarrhoea are also highest among these children because of neglect and unhygienic living conditions. Knowledge about healthy feeding practices, basic child care and protection against diseases is also limited in remote rural areas. Breast-feeding tends to be replaced by bottle-feeding very early, which poses a serious health risk, given the precarious sanitary conditions.

10. Around 85 per cent of the urban population have direct access to clean water, and an additional 7 per cent have access through public stand-posts. On the other hand, only 45 per cent of the rural population have access to clean water, with most obtaining water from open wells or through tankers that carry it long distances. Clean water is supplied by complete gravity systems using a well or spring as a source, a motorized pump and elevated storage reservoir; distribution is by gravity to house connections or community stand-posts. Because of the hydrogeological conditions and topography, hand-pumps are non-existent and technically inappropriate.

11. The management of solid waste needs to be examined so as to reduce its risk to households. The traditional Yemeni long-drop latrines are exposed to flies and animals and cause serious environmental pollution. The importance of simple hygiene (e.g. handwashing with soap) is not properly understood. There is, accordingly, considerable scope for promoting hygiene education at the community and family levels using simple messages similar to Facts for Life.

12. The existing education infrastructure faces problems in coping with both physical expansion and improving or even maintaining quality, including teacher training. At present, 66 per cent of children 7 to 14 years of age attend unity schools but only 19 per cent continue to secondary schools.

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READEX FICHE

13. Gender disparity in school enrolment and continuation remains pronounced, particularly in rural areas. Since independence in 1967, the percentage of girls in primary schools has increased only up to 35 per cent. Regional variations in girls' enrolment rates show lower rates among the poor and in more conservative regions, such as Shabwah Governorate. The problem is more pronounced among the nomadic population. Most illiterate adults are women living in rural areas; the percentage of girls in primary schools has remained below 40 per cent.

14. Women constitute one third of the work force. Excluding agriculture, which accounts for a high proportion of female employment, women work in traditional jobs as typists, teachers, textile workers and cleaners. Few women have access to higher wage brackets or opportunities for career development.

15. The government social service infrastructure is supported by strong grass-roots organizations, such as the General Union of Yemeni Women, Popular Defence Committee Organizations, the Federation of Yemeni Workers Union and the Farmers Union of Democratic Yemen. The mass media (radio and television), which reach an estimated 80 per cent of the population, also facilitate social mobilization activities.

PROGRAMME CO-OPERATION, 1985-1990

16. The 1985-1990 programme of co-operation focused on child survival and the needs of girls and women and coincided with the Government's development plan (1985-1990). However, because of an increase in planning levels and accelerated expenditure, the new programme will start in 1990.

17. The political and economic crisis of 1986 and subsequent austerity measures, such as a downwards revision of the national development plan, had a negative effect on programme implementation. However, the rural water supply component was a notable exception. Programme performance was generally below 1985 expectations in immunization, the control of diarrhoeal diseases (CDD) and ARI owing to administrative and managerial weaknesses in the Ministry of Public Health. These included a shortage of trained staff, the lack of supervision and clearly defined lines of responsibilities, communication gaps, inappropriate budgetary allocations and a shortage of funds for functioning costs.

18. In the health and nutrition sectors, CDD, the promotion of breast-feeding, immunization and other PHC services were offered nationally, with their extension to 72,000 people in the relatively deprived governorates of Al Mahrah, Shabwah and Socotra Island. This included the training of 360 health guides, the establishment of supervision and training teams at the district level and reorientation courses for existing PHC personnel.

19. The national CDD programme trained health personnel in oral rehydration therapy (ORT), developed communication and training materials and organized a national seminar on CDD. Oral rehydration salts (ORS) were provided by UNICEF through reimbursable procurement until 1987. Although local production had been

planned, the costs became prohibitive for the national budget and the idea was dropped. UNICEF provided another 150,000 ORS packets in 1989 for a national anti-dehydration drive, which was organized as part of region-wide activities.

20. Breast-feeding and appropriate infant feeding were promoted through the media and with the active involvement of the General Union of Yemeni Women. In accordance with the World Health Organization (WHO)/UNICEF International Code of Marketing of Breast Milk Substitutes, breast milk substitutes and milk powder were labelled.

21. In 1985, only 17 per cent of children under one year of age in Aden and less than 1 per cent in Al-Mahra Governorate were fully immunized. In 1988, the expansion of PHC services and UNICEF support increased immunization coverage of children under one year of age to 50 per cent for anti-tuberculosis vaccine, 35 per cent for three doses each of combined diphtheria/pertussis/tetanus and oral polio vaccines, and 28 per cent for measles vaccine. In 1989, two expanded programme on immunization (EPI) workshops were held to plan an accelerated vaccination exercise in order to achieve universal child immunization (UCI) by 1990. A national task force was created and a communication campaign was designed.

22. UNICEF assistance to the education sector focused on post-literacy activities for women and girls through the preparation and printing 15 readers containing information on important maternal and child health (MCH) issues such as immunization, breast-feeding, CDD and nutrition. Parents' attitudes toward the enrolment of girls in primary schools, and the magnitude of the problem were assessed in 1988, followed by the formulation and implementation of a pilot project in selected areas.

23. The study revealed that the introduction of co-education and the lack of toilet facilities have deterred conservative parents from enroling their daughters in school. Social customs, such as young marriage age, and economic constraints also contributed to the low enrolment rate for girls.

24. The project for universal primary education and literacy received supplementary funding in 1989. UNICEF supports 165 literacy and post-literacy classes annually, serving over 3,300 women, through teacher training, the provision of classroom materials and the development of television and radio programmes to promote and sustain literacy levels among neo-literate women. UNICEF also continued to assist the General Union of Yemeni Women in its post-literacy activities for women.

25. With day-care centres largely limited to urban areas, community-based and low-cost alternatives were explored. Four government planners were sent on study visits to India to observe models of day-care and pre-school programmes.

26. Political support for supplying drinking water to rural areas was demonstrated by the government allocation of $15 million and the decentralized management of water supply activities. Community mobilization was strong in this sector because the provision of drinking water to rural areas met well-perceived needs among the rural population. If the present trend in water supply continues, at least 75 per cent of the rural population will have access to safe water by 1995.

27. This project helped to develop the capacity of district technical support units to construct their own supply systems and link water supply to PHC through community mobilization and health education. In communities covered by the PHC programme, 90 out of 113 planned rural water supply systems were completed, providing 85,000 people with safe water. An estimated 45 per cent of the rural population was served by potable water supplies by the end of 1989. Three solar-powered pumps have also been installed on an experimental basis with contributions from the United Nations Capital Development Fund. With supplementary funding, UNICEF provided lightweight rigs, pipes, tools and vehicles for the operation and maintenance of water systems. Support was maintained for the in-service training of technicians, engineers and other staff concerned with public health, sanitation and maintenance. Since 1986, a water supply engineer and consultants have provided technical support. However, the promotion of public awareness on the proper use of water and sanitation, planned for nine previously assisted water schemes, did not progress as planned owing to a shortage of technical staff.

28. The sanitation component had to be considerably modified in order to conform to the realities and practices of the rural population. The feasibility of local sanitation systems that rely on community self-help schemes must be further explored, before technology is imported.

29. Involvement of the mass media in support of post-literacy activities for women, health education, immunization and PHC activities formed important components of each project. Because the lack of public awareness among the general population constrains not only health programmes but also education, literacy, women's development and overall social change, strategies and approaches for the next programme cycle (1990-1995) will place more emphasis on social mobilization activities.

30. In view of the decision to achieve UCI in 1990 and the need to seek Executive Board approval for funding for the 1990 programme, the Government and UNICEF agreed to recommend to the Board that the new programme start in 1990 and extend to 1995 to coincide with the next national development plan which covers the period 1991 to 1995. The Government will continue to assign high priority to the social sector, particularly health, education and water and sanitation, in its new national development plan.

31. The Government/UNICEF programme of co-operation for 1990-1995 has three major programme components: health and nutrition; rural water and sanitation; and women's development and girls' education. The major goals are to improve conditions for the survival and development of the Yemeni child; improve opportunities for women and girls to acquire more education and participate more fully and equally in the country's social and economic development; and raise awareness at all levels of the needs of Yemeni children and mothers. Social mobilization will be used as a means of educating and motivating communities to enlist their support for child survival and development (CSD) through increased co-operation with the mass media and popular organizations. UNICEF will also advocate increased awareness of child-related issues among planners and policy-makers.

RECOMMENDED PROGRAMME CO-OPERATION, 1990-1995

Recommended general resources: $5,500,000
Supplementary funds: $5,463,000

Recommended programme co-operation a/

(Thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health			
Immunization	2 206	913	3 119
Control of diarrhoeal diseases	1 094	500	1 594
Maternal and child health/nutrition	390	350	740
Acute respiratory infections	300	150	450
Subtotal	3 990	1 913	5 903
Rural water supply and sanitation	510	2 800	3 310
Women's development and girls' education	1 000	750	1 750
Total	5 500	5 463	10 963

a/ The breakdown by estimated yearly expediture is given in table 2.

b/ In addition, there are also funded supplementary funding projects shown in table 2.

Health and nutrition

32. This programme aims to halve IMR by 1995 from the present level of 118 per 1,000 live births, reduce U5MR from 197 to 70 per 1,000 live births and reduce MMR by 30 per cent from the present level of 100 per 100,000 live births. This programme has four projects: immunization; control of diarrhoeal diseases (CDD); improved nutrition through better infant feeding and weaning practices; and strengthened MCH services.

Expanded programme on immunization

33. EPI aims to reduce the incidence of neonatal tetanus to less than 1 per cent, eradicate poliomyelitis and reduce measles by 90 per cent, by raising and maintaining immunization coverage of children under one year of age to 80 per cent for each antigen by 1990 and from 30 to 70 per cent for tetanus toxoid for women 15 to 45 years old by 1995. The yearly coverage target for the programme is about 100,000 children under one year of age and 500,000 women of child-bearing age.

34. An accelerated immunization campaign will be launched in 1990 to expand rapidly immunization services throughout the country with the support of the PHC network and non-health infrastructure. Intensive training of health workers will be conducted, and a nation-wide communication campaign will increase public awareness and mobilize all sectors. UNICEF will provide all vaccines and cold-chain equipment. Support for the training and supervision of vaccinators will be increased. The monitoring and evaluation system will be strengthened through the provision of a mini-computer and the training of health personnel on data input and analysis. After 1990, support to EPI will be maintained to ensure sustainability. Sentinel centres for estimating coverage and assessing disease incidence will be developed and maintained to facilitate periodic cluster surveys.

Control of diarrhoeal diseases

35. The CDD project aims to reduce mortality by 50 per cent and morbidity associated with diarrhoeal diseases by 25 per cent among children under five years of age. Programme activities include effective case management, improved nutrition, improved personal and domestic hygiene, the use of abundant clean water, the integration of CDD with other PHC services, and increased ORT awareness among non-health workers and the mass media.

36. Programme activities include the training of senior paediatricians, health personnel, pharmacists, nurses, midwives and volunteer PHC guides through scheduled workshops at national and subnational levels. ORT will be promoted for the treatment of diarrhoeal cases in health centres and at home in order to reduce related hospital admissions among children by 90 per cent. Training manuals on CDD management for health personnel will be developed and printed. UNICEF will support two training and demonstration units in Aden and Mukallaist and the establishment of ORT corners in all health centres and hospitals.

37. Raising awareness of diarrhoea prevention and its management with ORT among the general public through the mass media will be particularly important in view of the high illiteracy rate among women in rural areas. Readers will also be developed for literacy and post-literacy classes.

38. The project will be monitored through the development of an information system to link field performance with central management through monthly reports. Five sentinel centres will be established in five major hospitals in order to monitor diarrhoeal mortality. An EPI/CDD review will be carried out every two years in collaboration with WHO and UNICEF to review project performance and its impact.

Maternal and child health/nutrition

39. To improve the quality of MCH care, existing MCH services will be integrated within the PHC network and expanded to include the care of pregnant women, nutrition education and the promotion of breast-feeding, appropriate infant feeding practices and use of growth charts.

40. UNICEF will support a series of training workshops for MCH workers, midwives, nurses, traditional birth attendants and other PHC workers to improve their MCH knowledge and skills. A referral service will be established, particularly for high-risk pregnant women, to ensure appropriate care. UNICEF will assist in providing simple weighing scales for women and children in all MCH centres and in developing training and educational material, such as slide sets, posters and flipcharts on antenatal and post-natal care, nutrition and monitoring child growth. Growth charts will be developed and introduced to all MCH centres.

41. A national MCH workshop will be organized to highlight maternal care issues and to advocate greater political and financial commitment. Media messages, literacy classes and co-ordination with grass-roots agencies, such as the General Union of Yemeni Women and the Local Defence Union, will also mobilize community involvement, raise awareness and improve the use of MCH services.

42. The project will be monitored through monthly reports based on the newly developed comprehensive MCH reports and field visits. Evaluations through surveys, to assess the effectiveness and impact of MCH service, will be made jointly with EPI and CDD reviews.

Acute respiratory infections

43. The magnitude of ARI as a cause of morbidity and mortality among children under five years of age has necessitated a better understanding of its epidemiology. Data collection and research within the existing PHC programme network will start in 1991.

44. Using WHO technical guidelines and manuals for ARI, and with UNICEF support, training material will be adapted to the national context. Training will start in 1993 at the governorate level and will expand to districts and subdistricts by 1994. Communication and educational promotion material will be developed for use by the media and non-health sector mobilization agents.

45. The project will be monitored through the development of special records for ARI treatment. Conformity with the recommended treatment will be assessed annually in order to measure project coverage.

Rural water supply and sanitation

46. The programme aims to increase access to safe water supply to 75 per cent of the settled rural population and to provide 70 per cent of the same population with sanitary means of excreta disposal. The provision of safe and adequate water and better sanitation facilities, combined with hygiene education, will reduce health hazards and the work-load of women and girls who are responsible for fetching the household water daily. In this programme cycle, 100 water supply systems will be installed, rehabilitated or improved to serve 100,000 unserved or underserved rural settled people through community stand-posts. Water quality and quantity control and the management of water resources will be co-ordinated with the United Nations Development Programme (UNDP), WHO, the Food and Agriculture Organization of the United Nations and the World Bank.

47. In the area of environmental sanitation, the same 100 communities will be motivated to upgrade existing excreta disposal facilities and to improve garbage disposal methods on a self-help basis. Other UNICEF support from supplementary funds will include the provision of supplies and equipment, technical assistance, training and logistics. A sanitation engineer will assist the Environmental Sanitation Division of the General Directorate for Local Government in the planning, formulation and implementation of rural sanitation programmes in addition to training of government staff.

48. Rural communities will be encouraged to operate and maintain water and sanitation facilities on a self-reliant basis through the training of community-level workers, pump operators and mechanics and through the provision of tools where required. Hygiene education will be included in the package of major communication and social mobilization efforts for child health and development to be disseminated through the media and community health guides. A knowledge, attitude and practice (KAP) and coverage survey in 1990 will be used for designing health education messages and materials.

Women's development and girls' education

49. The general objective of the programme is to achieve universal basic education for 75 per cent of Yemeni girls and women by 1995 through improved quality and access to both formal and non-formal education services.

50. The girls' education project aims to reduce the drop-out rate through the provision of sanitary facilities at schools, as well as to increase the number of trained female teachers since the lack of female teachers was found to be one of the main reasons why girls often drop out of school early. UNICEF will also sponsor a study tour for officials from the Ministry of Education to enrich their experience on the school health curriculum that is being developed with the United Nations Educational, Scientific and Cultural Organization (UNESCO)/UNICEF action-oriented curriculum.

51. The women's literacy project aims to expand the number of ongoing literacy and post-literacy classes to various parts of the country. UNICEF will continue to support orientation workshops for all literacy supervisors from the six governorates and districts and to strengthen their supervision and monitoring capacity and development of relevant monitoring tools.

52. A joint mid-term evaluation of the programme by the Ministry of Education and UNICEF is planned. It will assess programme effectiveness in increasing the rate of female enrolment and the number of female teachers, as well as awareness among rural and peri-urban women of basic health needs and the integration of health education material in the school curriculum.

Communications and social mobilization

53. The success of effective programme implementation will depend, to a large extent, on the communications and social mobilization strategy, which is integrated into all programme components, particularly through the mass media. The new

programme will utilize regional communication specialists to improve the quality of input and strengthen message impact. UNICEF will provide technical support for the design, development and production of various educational and promotional materials.

54. The General Union of Yemeni Women, the Local Defence Committee and other mass organizations will continue to support CSD interventions. Further linkages will be established and developed with other governmental sectors such as schools, the army and police.

Monitoring and evaluation

55. Each project will be evaluated according to its established objectives and targets. Annual programme reviews will assess progress and identify constraints for future course corrections. Building national capacities in programme monitoring and evaluation through technical assistance, training and the development of monitoring tools and an information system will be additional benefits. Joint reviews will be conducted with WHO and government counterparts every two years, and will be important for assessing programme performance, coverage and impact on child health projects.

Co-operation with other United Nations agencies and bilateral organizations

56. Close collaboration with various United Nations agencies will be maintained and further strengthened in the coming programme period, particularly in areas of joint interest and concern. Close consultations with UNDP, the World Food Programme, the United Nations Population Fund and WHO, which co-operated during the programme planning and development period, will be further extended. WHO and UNICEF will co-operate closely on EPI, CDD, ARI, nutrition and maternal health. There will be increased collaboration with UNESCO in the areas of girls' education, education for all and literacy. UNICEF will also maintain close collaboration with bilateral aid agencies and non-governmental organizations, particularly Médecins sans frontières and Rotary International in EPI, and Radda Barnen on MCH.

DEMOCRATIC YEMEN

Basic data: 1988 and earlier years			UNICEF country classification
Under-five mortality rate	197	(1988)	Very high U5MR
Infant mortality rate	118	(1988)	Very high IMR
GNP per capita	$420	(1987)	Low GNP
Total population	2•million	(1988)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1988
Births	(thousands)	73	89	102	111
Infant deaths (under 1)	(thousands)	13	13	13	13
Under-five deaths	(thousands)	21	21	22	22
Under-five mortality rate (per 1,000 live births)		294	236	212	197
Infant mortality rate (under 1) (per 1,000 live births)		177	142	127	118

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1983)	Moderate & severe	..	26
	Severe	..	..
Babies with low birth weight (%, 1985)		..	13
Children completing primary level (% of first grade, 1980)		40*	..

NUTRITION INDICATORS		About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1985)			80*/60*/55*
Prevalence of wasting (%, 1983)		..	8a/
Prevalence of stunting (%, 1983)		..	36a/
Daily per capita calorie supply (% of requirements, 1979-1981/1984-1986)		92	96
Food production per capita index (Index 1979-1981=100, 1980/1988)		98	86
Household expenditure (% of total income)	All food/cereals	../..	../..

HEALTH INDICATORS		About 1980	Most recent
ORS use rate (%, 1986-1987)			10
Access to health services	Total	30*	..
(% of population, 1980)	Urban/rural	.. /..	.. /..
Access to safe water	Total	49*	57*
(% of population, 1980/1988)	Urban/rural	84*/28*	92*/37*
Access to adequate sanitation	Total	38	53*
(% of population, 1980/1988)	Urban/rural	70 /15	87*/33*
Births attended by trained personnel (%, 1988)		..	10
Maternal mortality rate (per 100,000 live births)		..	..

Immunization		1981	1985	1987	1988
One-year-olds (%) immunized against:	Tuberculosis	9	17	41	50
	DPT	5	7	25	35
	Polio	5	7	25	35
	Measles	6	14	35	28
Pregnant women (%) immunized against	Tetanus	3	3	8	5

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DEMOCRATIC YEMEN

Basic data: 1988 and earlier years			UNICEF country classification
Under-five mortality rate	197	(1988)	Very high U5MR
Infant mortality rate	118	(1988)	Very high IMR
GNP per capita	$420	(1987)	Low GNP

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net)	Total	65/..	66/..
(%, 1980/1987)	Male	93/..	96/..
	Female	36/..	35/..
Secondary enrolment ratio (gross/net)	Total	18/..	19/..
(%, 1980/1987)	Male	25/..	26/..
	Female	11/..	11/..
Adult literacy rate, 15 years & older	Total	20	42
(%, 1970/1985)	Male/female	31/9	59/25
Radio/television sets			
(per 1,000 population, 1980/1987)		63/19	154/21

DEMOGRAPHIC INDICATORS		1970	1980	1985	1988	2000**
Total population	(millions)	1.5	1.9	2.1	2.3	3.4
Population aged 0-15 years	(millions)	..	0.9	1.0	1.1	1.6
Population aged 0-4 years	(millions)	..	0.3	0.4	0.4	0.6
Urban population (% of total)		32	37	40	42	51
Life expectancy at birth (years)	Total	42	47	50	51	57
	Male/female	42/43	46/48	48/51	50/53	56/59
Total fertility rate		7.0	6.9	6.7	6.7	5.9
Crude birth rate (per 1,000 population)		49	47	47	47	42
Crude death rate (per 1,000 population)		24	19	17	16	11

		About 1980	Most recent
Contraceptive prevalence rate		..	..
(%)			
Population annual growth rate	Total	2.8	2.9
(%, 1965-1980/1980-1988)	Urban	3.2	4.5

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate		..	-6.1
(%, 1980-1987)			
Inflation rate (%, 1980-1987)		..	5
Population in absolute poverty	Urban/rural	../20	../..
(%, 1978)			
Household income share	Top 20%/bottom 40%	../..	../..
(%)			
Government expenditure	Health/education	../..	6*/11*
(% of total expenditure, 1985)	Defence	..	..
Household expenditure	Health/education	../..	../..
(% of total income)			
Official development assistance:	US$ millions	100	80
(1980/1987)	As % of GNP	12	8
Debt service			
(% of goods & services exports, 1980/1987)		10	29

a/ Aged 0-65 months.

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

TABLE 1. BREAKDOWN OF ACTUAL EXPENDITURE FOR GENERAL RESOURCES AND SUPPLEMENTARY FUNDING UNDER PREVIOUS CO-OPERATION PERIOD, 1985-1989

(Thousands of United States dollars)

COUNTRY: DEMOCRATIC YEMEN
LATEST BOARD APPROVAL: 1985
GENERAL RESOURCES: $3,550,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	SF	GR	SF	GR	SF	GR	SF	GR	SF	Total
Health	1808	518	89	12	109		228	397	2234	927	3161
Water supply and sanitation	35	930	22	2		321		54	57	1307	1364
Nutrition							3		3		3
Education	80		6				153		239		239
Community organization and development		21								21	21
Women-centred programme	190	20	49	9			237	1	476	30	506
Emergency						5				5	5
Planning and project support	95		53		323	5	84	103	555	108	663
Freight	358	61							358	61	419
GRAND TOTAL	2566	1550	219	24	432	331	705	555	3921	2459	6380

GR = General resources.
SF = Supplementary funding.

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TABLE 2. PLANNED EXPENDITURE FOR GENERAL RESOURCES, NEW SUPPLEMENTARY FUNDING AND FUNDED SUPPLEMENTARY FUNDING

(Thousands of United States dollars)

Country: DEMOCRATIC YEMEN Period covered: 1990-1995	Funding status	1990	1991	1992	1993	1994	1995	Total
Health								
Immunization a/	GR	656	350	300	300	300	300	2206
	FSF	90						90
	NSF	153	160	165	167	168	100	913
Control of diarrhoeal diseases	GR	144	200	200	200	180	170	1094
	NSF		100	100	100	100	100	500
Other health	GR	200	100	100	100	100	90	690
	NSF		50	150	150	100	50	500
Subtotal, health	GR	1000	650	600	600	580	560	3990
	FSF	90						90
	NSF	153	310	415	417	368	250	1913
Water supply and sanitation	GR		50	120	100	120	120	510
	FSF	900	1100					2000
	NSF			700	700	700	700	2800
Education and women in development b/	GR		200	180	200	200	220	1000
	FSF	68						68
	NSF		150	150	150	150	150	750
TOTAL	GR	1000	900	900	900	900	900	5500
	FSF	1058	1100					2158
	NSF	153	460	1265	1267	1218	1100	5463
GRAND TOTAL		2211	2460	2165	2167	2118	2000	13121

GR = General resources.
NSF = New supplementary funding.
FSF = Funded supplementary funding.

a/ In addition, $1,000,000 was funded from under five mortality fund for 1990.
b/ In addition, $325,000 for unfunded supplementary funding programme.

TABLE 3. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: DEMOCRATIC YEMEN	Number of posts	1990-1991 amount (Thousands of US dollars)
FINANCED FROM 1990-1991 APPROVED BUDGET:		
International Professional established posts	2	397
Local national Professional and General Service established posts	7	226
Operating costs		189
Total	9	812
FINANCED FROM PROGRAMME FUNDS: a/		
International Professional project posts		
General resources	1	175
Supplementary funds	1	195
Local national Professional and General Service project posts		
General resources	2	100
Supplementary funds	2	87
Total	6	557

a/ For information source, see 1990 post authorization table, revised October 1989.

Annex

SELECTED LIST OF STUDIES AND EVALUATIONS

1. An analysis of the situation of women and children. Government of Democratic Yemen and UNICEF, Aden, November 1989.

2. Nutrition, growth and health among preschool children in the People's Democratic Republic of Yemen 1982-1983. Nasser, Kristiansson, 1984.

3. UNESCO basic data sheets, 1989.

4. National EPI coverage survey (cluster survey). Ministry of Public Health/UNICEF, July 1988.

5. A study on girls' education. Ministry of Education, Education Research Centre and UNICEF, June 1988.

6. A review of national plan for control of diarrhoeal diseases (CDD). Ministry of Public Health/UNICEF, December 1987.

7. KAP focus group survey of mothers' attitude to child immunization. Ministry of Public Health, 1987.

8. A study on PHC services extension plan. Ministry of Public Health, June 1987.

9. The 1984 literacy campaign in the People's Democratic Republic of Yemen (case study), May 1987.

10. Follow-up study on nutrition, growth and mortality among pre-school children in Democratic Yemen. EMR Health Services Journal No. 2, pages 10-19, WHO, Alexandria, 1987.

11. Control of diarrhoeal diseases in the People's Democratic Republic of Yemen. WHO Assignment Report, Nasser, April-May 1984 (WHO consultancy service).

12. Anthropometric evaluation of nutritional status and growth of primary school children in Aden. Haitami, unpublished thesis, 1987.

13. National plan of operations for control of acute diarrhoeal diseases in the People's Democratic Republic of Yemen, Baruad, 1982 (WHO consultancy report).

14. A study on EPI report system in the People's Democratic Republic of Yemen, Desve, Gilles & MSF Team, Aden, April 1988.

15. Assignment report on water and sanitation sector in Democratic Yemen, 5-18 July 1985 (P. G. Clark, WHO consultant).

16. Assessment of environmental health situation in the People's Democratic Republic of Yemen, Ghougassion, B. S., 22 August 1984.

17. Seiyun regional water supply project. World Bank Report No. 4357a, People's Democratic Republic of Yemen, 13 October 1986.

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Programme Committee
1990 session

FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Islamic Republic of Iran

The Executive Director recommends that the Executive Board approve an amount of $2,500,000 from general resources, subject to the availability of funds, and an amount of $2,500,000 in supplementary funds, subject to the availability of specific-purpose contributions, for the country programme of the Islamic Republic of Iran for the period 1991-1995.

* In order to meet documentation deadlines, this document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme co-operation at the end of 1989, will be contained in the "Summary of 1990 recommendations for general resources and supplementary funding programmes" (E/ICEF/1990/P/L.1).

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THE SITUATION OF CHILDREN AND WOMEN

1. During the last decade, life in the Islamic Republic of Iran was dominated by the adverse consequences of its eight-year war with Iraq: the large-scale destruction of homes; disrupted social services; stagnancy in development projects; displaced and unaccompanied children; children with disabilities; single parents; and war widows. Some 2.5 million Afghan refugees further aggravated the situation, adding to the burden on existing services and facilities. The war also had adverse effects on the Iranian economy. The price of oil dropped, as did exports and productivity. The economy was characterized by a negative growth rate in gross domestic product of 4.5 per cent (1978-1988). In spite of this negative economic scenario and government budget cuts, government allocations for health and education increased in 1988, signifying a commitment to social services.

2. As the Government and UNICEF prepare for the 1991-1995 programme of co-operation, the climate seems very favourable for an effective response to the needs of children and women. The UNICEF office in Tehran is being upgraded to the representative level in 1990.

3. The supreme power of the country is the imam (Velayet-e-Faghih). The president, elected by the people, is the second highest authority and responsible for implementing the Constitution and directing the judicial, legislative and executive branches, along with the 24 ministers who are nominated by the president and approved by the Parliament. The governors of the 24 provinces are appointed by the Interior Minister to act as focal points for the central Government with powers to co-ordinate the activities of 190 districts, 465 cities and towns and approximately 60,000 villages.

4. The Islamic Republic of Iran has a total land area of 1.65 million square kilometres and about 55 million people. The population is growing rapidly, at an annual rate of 3.2 per cent, a result of very high fertility coupled with declining mortality. Urbanization has been very rapid in recent years. Some 54 per cent of all Iranians live in urban areas and one fifth live in the Tehran metropolitan area. This has serious implications since urban growth has not been matched by expanded basic services, and some peri-urban areas are already turning into slums.

5. The Constitution recognizes the right of all citizens to health and an equitable distribution of health services, based on the principles of the Islamic religion. A 20-year master plan of health for the period 1983-2002 has been developed encompassing the Government's commitment to achieving the goal of "Health For All" by the year 2000. The plan focuses on services for mothers and children as the most vulnerable group based on the principles of self-health care, equity, synergism and community participation.

6. In 1972, the Islamic Republic of Iran experimented with a strategy to promote primary health care (PHC) through a multi-tiered network of fixed health facilities, including rural health houses, in which two trained health workers (one male and one female) provided maternal and child health (MCH) and preventive services. A referral system consisting of a rural health centre, an urban health centre, a district health centre, a hospital and, finally, a specialized hospital

forms the rest of the PHC network. Each province has a provincial health centre for organizational and administrative support. The system underwent a tremendous expansion in the 1980s and as of January 1989 consists of 6,500 health houses, 1,700 rural health centres, 1,500 urban health centres, 80 district health centres and 24 provincial health centres.

7. The health house and the rural health centre form the core of the system, with each health house providing active home-level services to about 300 households in one main village and one or two satellite villages. Health workers receive two years of theory and practical training and are placed in the health house of their native village. Their recognition in the community and the records they keep are key contributions to the satisfactory operation of the rural PHC system. Health workers are supervised by their training centre and the rural health centre.

8. The PHC network has helped to reduce infant and child mortality by expanding in deprived areas where mortality has been high. In some rural areas, where the PHC network has been operational for more than three years, the infant mortality rate (IMR), child mortality rate and the maternal mortality rate (MMR) have dropped sharply and are below national averages. This is evident from the excellent records that are kept in each health house.

9. According to a government survey, and in spite of many adverse conditions, IMR declined dramatically from 114 per 1,000 live births in 1978 to 45 per 1,000 live births in 1988. The under-five mortality rate (U5MR) also declined, from 169 per 1,000 live births in 1978 to 56 per 1,000 live births in 1988. UNICEF estimates IMR at 55 per 1,000 live births and the U5MR at 72 per 1,000 live births in 1988. Immunizable diseases, in particular neonatal tetanus, diarrhoeal diseases, and acute respiratory infections (ARI), are major contributors to both infant and child mortality and morbidity. Reliable national data on protein-energy malnutrition is not available, but it is estimated that 30 per cent of children suffer from moderate to severe cases. Growth faltering is most significant during ages one to three years. Only 5 per cent of mothers are unable to breast-feed their babies.

10. Between 7 million and 15 million people suffer from goitre in varying degrees. In some mountainous areas, prevalence is as high as 90 per cent among women in the child-bearing age group. In addition, a high proportion of schoolchildren (15 per cent) may also be affected.

11. MMR declined from 140 per 1,000 live births in 1984 to 91 per 100,000 live births in 1988. However, the rate is still too high, and the disparity between rural and urban areas is wide: 137 to 41. High maternal mortality is related to the large number of babies (30 per cent) delivered to mothers in the high-risk category (18 to 35 years old). It is also related to high fertility, a high proportion of early marriages, low contraceptive practice and short intervals between pregnancies. Low birth weight affects 9 per cent of new-borns. Some 63 per cent of deliveries take place in hospitals, although the figure is only 41 per cent in rural areas, compared with 85 per cent in urban areas. As many as 50 per cent of births in rural areas are attended by untrained persons. PHC health workers are not trained to handle deliveries. Moreover, the community does not trust young health workers for deliveries. Birth attendants have not yet been

integrated into the PHC system. Should emergency medical assistance be needed at delivery, transportation facilities are not immediately available in some remote rural areas.

12. Environmental health has received high government priority in the last few years, with increased budget allocations for the provision of safe drinking water to rural areas and the expansion of waste disposal and sanitation systems. In 1986, 70 per cent of houses had access to piped water, while only 2 per cent had no access to water and sanitary facilities. At least 60 per cent of the rural and 90 per cent of the urban population have access to safe drinking water. Adequate and hygienic waste disposal in the house or the immediate vicinity is available to 90 per cent of urban and 24 per cent of rural homes.

13. Total primary school enrolment is 81 per cent, but only about 50 per cent in rural areas (41 per cent for girls and 56 per cent for boys). The highest drop-out rate occurs during the second and third years of schooling, although the total number of drop-outs is down from 25 per cent in 1982 to 14 per cent in 1986. Facilities for pre-school education are limited mainly to the urban areas.

14. The literacy rate of the rural population is estimated at 62 per cent (72 per cent among males and 52 per cent among females). There are wide regional variations in the literacy rates for females, from as low as 14 per cent to as high as 78 per cent. Non-formal education, which has contributed significantly to raising the literacy rate, is the responsibility of the Literacy Foundation which is headed by the senior clergy. It has branches in all provinces, districts and rural areas and has pledged to provide opportunities for all age groups, especially women, to become literate.

15. Mass communication is almost universal. There are 10 million radio receivers and 5 million television sets in the country. More than 80 per cent of the urban population watches television and listens to at least two radio stations each day, and newspapers have a daily circulation of around 1 million.

PROGRAMME CO-OPERATION, 1989-1990

16. The UNICEF programme of co-operation has been developed with the Government on an annual basis since 1984. During the previous period of co-operation, the Islamic Republic of Iran implemented a highly successful child survival campaign which included the following four components: universal child immunization (UCI); oral rehydration therapy (ORT); breast-feeding; and improved weaning practices. It was the first time that social mobilization techniques had been used as major components of the programme. Leaders at the highest political level were involved, as well as religious leaders, service delivery institutions, popular and professional organizations and the general public. The PHC network was instrumental in efforts to heighten awareness, spread knowledge and improve practice by establishing systems that put child survival and development (CSD) services within the reach of every mother.

17. Dissemination of knowledge, simultaneously combined with the provision of services, contributed to the achievement of UCI and other goals. In the

immunization programme, there was massive training of personnel, the establishment of a cold-chain for vaccine and the organization of mobile teams to reach the unreached. There were also changes in the immunization schedule, a reduction of missed opportunities and the mobilization of religious and legal support for compulsory immunization.

18. Immunization coverage for children less than one year old rose dramatically from 1986 to 1989: from 44 to 89 per cent for anti-tuberculosis vaccine (BCG); from 56 to 90 per cent for measles vaccine; from 60 to 89 per cent for three doses of diphtheria/pertussis/tetanus vaccine (DPT3); and from 59 to 89 per cent for three doses of oral polio vaccine (OPV3). Coverage with two doses of tetanus toxoid (TT2) doubled to 54 per cent. ORT-related activities included the training and orientation of all health workers; the setting up of ORT centres; and the ready provision of ORT services through the PHC network, particularly at the health house and health centre levels. The local production of oral rehydration salts (ORS) was increased to 10 million sachets annually, although there was still a shortfall that was remedied by the Government and UNICEF with imports. ORT management of diarrhoeal cases has increased from below 20 per cent to 65 per cent.

19. Education, communication and training support were provided to promote growth, protect breast-feeding and improve weaning practices. Government and UNICEF representatives advocated the provision of more food supplements to children and pregnant mothers, improved child spacing, female literacy and education for girls.

20. In 1987, UNICEF supported an emergency rehabilitation of the water supply network devastated by floods in Fars Province. Another emergency project was prepared in 1988 after the cease-fire to rehabilitate areas affected by war. That project, called "Rebuilding for children", aims to rehabilitate and expand the PHC network to war-affected areas. As part of the project, UNICEF, along with the Government, will equip and set up 1,200 rural health houses, 200 rural health centres and 15 training centres for health workers.

Lessons learned

21. The most important lesson learned from the past year of co-operation is that doing more for children does not necessarily entail more expenditure by the Government or by UNICEF. Investment in education and the empowerment of mothers through social mobilization has contributed to a greater utilization of existing PHC services.

22. In order to reach the last 20 per cent - in immunization coverage or in education on proper weaning practices - it is imperative for a country of such size and diversity to reach every single family and to teach mothers on a one-to-one basis. A permanent community-based structure, such as the PHC network, is the way to sustain such services.

23. The use of pilot projects as the first stage in phasing a programme provides invaluable inputs for planning national projects, contributes to confidence in effective implementation and prevents costly mistakes and failures. The proper and comprehensive planning for the national ORT campaign in 1988 was a result of the provincial ORT campaign in 1987, in which only three provinces were covered.

24. In order to reduce the disparities between different geographical areas, and especially between rural and urban areas, it is imperative to design province-specific social mobilization strategies.

25. The PHC network provided a valuable foundation for the delivery of integrated services. The close link between communication, social mobilization and service delivery is essential, especially to ensure programme sustainability.

RECOMMENDED PROGRAMME CO-OPERATION, 1991-1995

Recommended general resources: $2,500,000
Supplementary Funds: $2,500,000

Recommended programme co-operation a/

(In thousands of United States Dollars)

	General resources	Supplementary funds b/	Total
Health			
Immunization	250	-	250
Control of diarrhoeal diseases	250	-	250
Other health	750	2 500	3 250
Subtotal	1 250	2 500	3 750
Nutrition	500	-	500
Advocacy	500	-	500
Planning and social statistics	250	-	250
Total	2 500	2 500	5 000

a/ The breakdown for estimated yearly expenditures is given in table 2.

b/ In addition, there are also funded supplementary funding projects shown in table 2.

26. The programme of co-operation is based on government plans and development policies and on priority problems and needs identified in the situation analysis. It was developed within the context of the country's 1989-1994 national development plan that had among its goals the reconstruction of the war-damaged infrastructure; the development of educational facilities, particularly for girls; improvement of equity and social justice; and fulfilment of basic health needs.

27. Major objectives of the 1991-1995 programme of co-operation are: (a) to reduce IMR from 45 to 36 per 1,000 live births and U5MR from 56 to 45 per 1,000 live births; (b) to reduce maternal mortality from 91 to 50 per 100,000 live births; (c) to reduce malnutrition among infants, pre-school children and pregnant mothers; (d) to empower all parents, particularly mothers, with knowledge and information necessary to promote the well-being of their children; (e) to prioritize the needs of children by ensuring that the child is kept on the political agenda and that structural adjustments do not interfere with services for children; and (f) to improve the capacity of the Government to monitor and evaluate the situation of children and women for better future programme formulation.

Health

28. In order to reduce IMR, U5MR and MMR, the programme will include five projects: expansion of the PHC network; expanded programme on immunization (EPI); control of diarrhoeal diseases (CDD); control of ARI; and safe motherhood.

Expansion of the primary health care network

29. The main goal is to expand the PHC network so that it reaches all rural people. There will be a special effort to implement services in war-affected provinces, socio-economically deprived provinces and peri-urban areas where services are much fewer than in other areas. Thus, there is an inherent aim to ensure an equitable distribution of services. Activities will focus on expanding the number of health facilities and integrating all programme components. Support will be provided for the training of health workers, pharmacists and medical students in the PHC approach.

30. UNICEF support will be provided for the training of 7,000 female and 7,000 male health workers; developmental training material for the health auxiliaries; communication and education materials for the communities; workshops on PHC for professional medical staff and students; and improvement of the management information system. The Government will build about 500 rural health houses, 100 rural health centres and five health worker training centres and will equip them jointly with UNICEF to serve the rural population of 23 million. UNICEF will assist in the training of 1,200 rural health workers (600 female and 600 male) for these health units. The project will also cover improvement of service quality throughout the network.

Expanded programme on immunization

31. EPI aims to consolidate, improve and sustain the universal coverage of infants already achieved with DPT3, OPV3, measles vaccine and BCG. It also aims to increase the coverage of pregnant women with tetanus toxoid to over 80 per cent.

Special emphasis will be placed on the eradication of polio, the reduction of measles morbidity and mortality and the elimination of neonatal tetanus.

32. Efforts will be made to achieve uniform coverage throughout the country, with special focus on the war-torn provinces where services have been severely curtailed, deprived provinces and peri-urban areas. Main activities will include monitoring the regular vaccination of infants and pregnant mothers, improving local vaccine production, maintaining an effective cold-chain, integrating the private sector vaccination centres into the national programme, improving surveillance and reporting and ensuring sustained public awareness.

33. UNICEF support will be primarily in training, social mobilization, improvement of the management information system, monitoring and evaluation.

Control of diarrhoeal diseases

34. Diarrhoea still kills more than 15,000 Iranian children under five years old annually. Thus, the main goal of the project is to reduce infant and child mortality caused by diarrhoeal diseases by ensuring the universal practice of ORT among mothers, including the proper use of ORS. The programme will also support the protection of breast-feeding practices, continued feeding during diarrhoeal episodes and efforts to reduce diarrhoea-related morbidity through better personal and domestic hygiene, safe drinking water and sanitary facilities. The main service coverage objective is to ensure the correct usage of ORT in the management of diarrhoeal episodes and to contribute to the reduction of child mortality by 75 per cent. The current high levels of ORT awareness will be sustained by ensuring that 80 per cent of all diarrhoea cases among children under five years old are treated with ORT. Local ORS production capacity will be improved and the ORS sachet size will be standardized. Regular training will be organized for health personnel. Based on the past successful experiences, social mobilization and communication techniques will continue to be used to sustain the process of empowering the mother with ORT knowledge through face-to-face education and training.

35. UNICEF resources will be utilized (a) to reinforce the knowledge and practice of ORT among key medical professionals and private-sector groups; (b) for special communication campaigns in provinces where the practice of ORT is low; and (c) for monitoring, reporting and evaluation as integral components of project management.

Control of acute respiratory infections

36. ARI are a major contributor to infant and child mortality, accounting for 13.6 per cent of all infant and child deaths. Although ARI constitute a serious problem in the mountainous provinces, they have not received much priority. The goal of the project is to remedy the situation. The main areas for action include establishing a standardized treatment schedule; establishing an outreach screening and referral system; and implementing a communication programme to heighten public awareness, with an emphasis on both prevention and the early treatment of mild and moderate cases and early diagnosis of severe cases. Schoolteachers and all health workers will also be mobilized to communicate on an interpersonal level. ARI control measures will be integrated into the PHC service network.

37. The main goal will be to contribute to a 25 per cent reduction of infant and under-five mortality related to ARI. Special emphasis will be placed upon provinces of greatest ARI prevalence. Efforts will also be made to raise the awareness of 80 per cent of mothers regarding prevention and early treatment, and 80 per cent of caregivers will be trained in ARI management, including the administration of antibiotics. Some 90 per cent of children affected will be screened at health centres and health institutions. The service coverage objective will also focus on establishing a common ARI treatment schedule for 90 per cent of infants and pre-school children. One of the initial attempts will include estimating prevalence rates by province and identifying risk factors such as low birth weight, malnutrition, traditional practices in early infancy that could contribute to ARI and environmental factors such as air pollution. UNICEF support will be mainly in the development of training materials, consultancy, training courses and workshops, communication and social mobilization.

Safe motherhood

38. The main goal is to contribute to a reduction in MMR from 91 per 100,000 live births in 1988 to 50 per 100,000 live births by 1995. Maternal mortality has not declined as rapidly as infant mortality. According to the 1989 IMR survey, it was 47 per 100,000 live births in urban areas and 138 per 100,000 live births in rural areas. About 50 per cent of births are attended to by untrained birth attendants and 40 per cent of children are born to mothers in the risk category (under 20 years and over 35 years of age). A high fertility rate of 5.2 and inadequate birth spacing are critical factors affecting maternal health.

39. The main coverage objective is to expand the deliveries conducted by trained care providers to at least 80 per cent and, at the same time, to improve the quality of care. Raising the coverage of pregnant mothers with TT2 to over 80 per cent will help to reduce neonatal tetanus as well as contribute to its eventual elimination as a cause of infant mortality. The programme aims to reach at least 95 per cent of all pregnant women with antenatal and post-natal care and to provide them with safe facilities for delivery. About 40,000 traditional birth attendants (TBAs) will be trained by 1995 to serve in 195 districts, covering 60,000 villages. The main project activities include education on child spacing; the provision of antenatal and post-natal care, including food and iron supplements; the identification of high-risk mothers and ensuring proper referral systems; and the integration of maternal care services into the PHC network. There will also be continuous training for all health workers on safe motherhood, and efforts will be made to upgrade the practical obstetrical skills of doctors. Relevant studies will be conducted to determine the causes of maternal mortality and morbidity, since this is an area in need of more data.

40. UNICEF will support the training of health staff and midwives and social mobilization on different aspects of safe motherhood. Inputs will include supplies such as midwifery kits and weighing scales in high-MMR provinces.

Nutrition

Growth promotion

41. Although a high percentage of children have growth charts, weighing is not done regularly, and information on the charts is neither properly interpreted nor properly used. In addition, adequate nutritional advice is not given to mothers. The project will aim to reduce infant and under-five mortality and morbidity related to protein-energy malnutrition. The major emphasis will be on ensuring the use of the chart as a tool for nutrition surveillance and growth promotion among all infants and pre-school children. Efforts will be made to produce an adequate number of charts and to make them widely available to all infants through the PHC network and maternity hospitals, including private-sector outlets. Weighing scales will be provided to all health units to establish a programme of regular weighing. Health workers will be trained not only in correct recording, but also in proper interpretation of the chart and how to take remedial action when necessary. More public awareness activities will be undertaken on the importance of growth promotion in terms of its links with the chart, weighing, breast-feeding, proper weaning and control of infections, such as immunizable diseases, diarrhoea and ARI. Efforts will be made to establish appropriate referral facilities for children who are severely malnourished and in need of rehabilitation services. Research and studies will be undertaken and attempts will be made to set up a nutrition surveillance system at the national level. The importance of child spacing in the interest of health, nutrition and growth of children will be emphasized.

Control of iodine deficiency disorders

42. The main goal is to prevent and control iodine deficiency disorders (IDD) among women and children and to reduce the percentage of schoolchildren with goitre to 10 per cent. The main service coverage objective is to prevent and control IDD through the provision of at least 150 micrograms of iodine per day to every person at risk by 1995 by producing iodized salt and distributing it widely, providing iodized oil injections to people in hyper-endemic areas and increasing public awareness of IDD control measures. Relevant baseline research and iodization of water and bread will be undertaken depending on the outcome of studies to be undertaken. Since ordinary rock-salt is almost freely available, the PHC network will have a significant role in promoting and distributing iodized salt. UNICEF resources will be used to develop a system for monitoring, supervision and surveillance of IDD, salt distribution and use, iodized oil injections, consultancy, training and workshops for different levels of health staff.

Institutionalization of social mobilization

43. This programme component will contribute to ensuring the achievement of the following programme objectives: that all parents have the knowledge necessary to promote the well-being of children; that the child is kept on political agendas; and that structural adjustments do not have a negative impact upon services for children. Past co-operation shows that, while every programme should continue its routine training and community education activities, an organized and recognized body of skilled persons is needed for mobilizing intersectoral resources and

large-scale community education. The existence of such a body under each programme or department is neither feasible nor cost-effective. However, it is possible, especially after the experiences of the 1988 child survival campaign, to strengthen and develop capabilities of the existing Health Education Department of the Ministry of Health and Medical Education. That department will be equipped with social mobilization expertise and intersectoral task groups to complement the activities of other programmes for mothers and children.

44. To support the health programme, the above programme has as its aims: (a) to provide families, especially mothers, with the knowledge of how they can protect the health and well-being of their children; (b) to spread basic knowledge of PHC and child survival to the entire population through a well-orchestrated, mass media and interpersonal communication effort linked with service provision; (c) to establish a long-term strategy to help support a series of objectives such as sustaining UCI and CDD projects, promoting ARI control and growth promotion, improving maternal health, establishing the control of IDD and promoting safe motherhood through initiatives in maternal health.

45. Other important children's issues to be advocated include child protection through the adoption of the Convention on the Rights of the Child, female literacy and policies to ensure that structural adjustment does not negatively affect services for children. In addition, a programme for children in difficult circumstances is needed, especially for those exposed to war and its aftermath. Activities will include observing annual CSD days to heighten awareness; establishing a free flow of information on the problems of children among different sectors; providing training facilities; conducting knowledge, attitude and practice (KAP) studies; and networking with institutions such as the Welfare Organization, the Literacy Foundation, the Imam's Foundation and the War-Disabled Foundation. The service coverage objective will include reaching the entire public with these important messages on the well-being of children.

46. The main tasks for institutionalization will include the establishment of a permanent high-level committee for children either at the parliamentarian level (Child Commission) or at the presidential level with membership of the ministers for Plan and Budget, Health, Education, Information and Islamic Guidance, the heads of Islamic Republic Broadcasting (radio and television) and the Women's Association. Corresponding committees headed by the governors will also be established at provincial and district levels. Eight national centres, one for every three provinces, will be established to serve as social mobilization and community education resource pools. National working committees will be composed of the Under-Secretary of the Ministry of Health, the Director-General of the Ministry of Education and their respective counterparts from other related ministries.

47. The promotion of female literacy is an area in need of advocacy through social mobilization. Raising levels of literacy and reducing disparities between rural and urban areas will not only pave the way for enhanced CSD, but will also contribute to improved maternal health, reduced fertility rates and, most important, an improved quality of life for the family. It will also contribute to the goal of "Education For All".

48. The main task of UNICEF is to build technical capacities, develop communication materials and support training activities. The project will be monitored in terms of implementation aspects and evaluated in terms of outcome and impact.

Monitoring the situation of children

49. During the last five years, many nation-wide surveys and studies have been carried out. If all of these large-scale studies had been analysed within the context of the situation of children, they could have influenced national policies, perspective planning and target setting for the 5- and 20-year plans. The studies would have contributed to the definition of province-specific strategies to reduce national disparities in indicators related to MCH.

50. The objective of this programme component is to improve the capacity of the Government to monitor and evaluate the situation of children. The main activities will include establishing an inventory of information, selecting key indicators on the situation of children and identifying methods to improve the efficiency and accuracy of existing data collection systems. Activities will include setting up a current data bank with information on the major indicators of the situation of children, in particular CSD, for national and regional programming purposes. The data bank will be prepared and utilized by the Ministries of Health, Plan and Budget, Education and the Universities, and will be available to other Ministries and organizations. It will be established in the Ministry of Health and Medical Education. Support will also be provided for updating of the situation analysis of children and women in the Islamic Republic of Iran on a regular basis so that it can be an effective advocacy tool to expand programmes for children. A central bureau will be established for collecting, analysing, disseminating and monitoring the situation of children within the network of a regional demographic and surveillance system. Efforts will be made to develop capabilities and capacities for rapid assessment surveys among local groups. Also, UNICEF will support training in the areas of bio-statistics, computerization, report writing and data analysis. The strategy will focus on local capacity-building based on the strengths of the existing system.

51. A system will be developed to collect, computerize, analyse and use vital statistical records on the "vital statistics form" of health houses in the PHC system. Studies will be undertaken on children in difficult circumstances, problems among war-affected children, the disabled, abandoned children and street children.

52. UNICEF will support the training of professional staff in software, data processing, analysis and consultancies for the purpose of national reviews and report writing.

Co-operation with other United Nations agencies

53. UNICEF and the World Health Organization (WHO) have been jointly co-operating with the Government on MCH programmes. The United Nations Development Programme (UNDP) funded a project to increase vaccine production in order to support the

United Nations goal of UCI by 1990. The Office of the United Nations High Commissioner for Refugees (UNHCR) supported the UNICEF programme in provinces with a high population of Afghan refugees. Co-ordination between UNDP, UNICEF, UNHCR, the World Food Programme and the Office of the Co-ordinator for United Nations Humanitarian and Economic Assistance Programmes Relating to Afghanistan on rehabilitation programmes for the repatriation of Afghan refugees began in 1989.

54. Co-ordination and collaboration with concerned United Nations organizations will continue both in the planning as well as in the implementation, monitoring and evaluation aspects of the programme. The report of the latest Joint Programme Review Meeting of WHO and Government and the country programmes of UNDP and UNHCR have been consulted in preparing this recommendation. Regular programme meetings will be held with WHO.

IRAN (ISLAMIC REPUBLIC OF)

Basic data: 1988 and earlier years			UNICEF country classification
Under-five mortality rate	72x/	(1988)	Middle U5MR
Infant mortality rate	55x/	(1988)	Middle IMR
GNP per capita	..		
Total population	53 million	(1988)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1988
Births	(thousands)	1275	1685	2010	2175
Infant deaths (under 1)	(thousands)	170	150	141	120
Under-five deaths	(thousands)	249	219	207	157
Under-five mortality rate (per 1,000 live births)		195	130	103	72x/
Infant mortality rate (under 1) (per 1,000 live births)		133	89	70	55x/

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1980)	Moderate & severe	43	..
	Severe	..	..
Babies with low birth weight (%, 1979/1982)		14	5
Children completing primary level (% of first grade, 1969/1986)		70	83

NUTRITION INDICATORS		About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1988)		../../..	91*/73*/51*
Prevalence of wasting (%, 1980)		23	..
Prevalence of stunting (%, 1980)		55	..
Daily per capita calorie supply (% of requirements, 1979-1981/1984-1986)		124	138
Food production per capita index (Index 1979-1981=100, 1980/1988)		98	89
Household expenditure (% of total income)	All food/cereals	../..	.. /..

HEALTH INDICATORS		About 1980	Most recent
ORS use rate (%, 1988)			65*
Access to health services	Total	..	80*
(% of population, 1988)	Urban/rural	../..	95*/65*
Access to safe water	Total	..	79*
(% of population, 1988)	Urban/rural	../..	95*/60*
Access to adequate sanitation	Total	..	58*
(% of population, 1988)	Urban/rural	../..	90*/25*
Births attended by trained personnel (%, 1988)		..	70*
Maternal mortality rate (per 100,000 live births, 1986)		..	120

Immunization		1981	1985	1987	1988
One-year-olds (%) immunized against:	Tuberculosis	6	64	56	73
	DPT	29	51	74	80
	Polio	47	51	74	80
	Measles	48	51	76	90
Pregnant women (%) immunized against	Tetanus	2	23	12	50

IRAN (ISLAMIC REPUBLIC OF)

Basic data: 1988 and earlier years

UNICEF country classification

Under-five mortality rate	72x/	(1988)	Middle U5MR
Infant mortality rate	55x/	(1988)	Middle IMR
GNP per capita	..		

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net)	Total	88/..	114/94
(%, 1980/1987)	Male	../..	122/98
	Female	../..	105/89
Secondary enrolment ratio (gross/net)	Total	43/..	48/..
(%, 1980/1987)	Male	../..	57/..
	Female	../..	39/..
Adult literacy rate, 15 years & older	Total	29	51
(%, 1970/1985)	Male/female	40/17	62/39
Radio/television sets			
(per 1,000 population, 1980/1987)		165/..	236/53

DEMOGRAPHIC INDICATORS		1970	1980	1985	1988	2000**
Total population	(millions)	28.4	38.9	47.6	53.1	74.5
Population aged 0-15 years	(millions)	..	18.2	21.6	24.2	33.8
Population aged 0-4 years	(millions)	..	6.7	8.3	9.5	11.4
Urban population (% of total)		41	49	52	54	61
Life expectancy at birth (years)	Total	55	60	63	66	70
	Male/female	55/54	59/61	62/64	66/66	69/71
Total fertility rate		6.8	5.8	5.6	5.6	4.6
Crude birth rate (per 1,000 population)		45	43	42	42	33
Crude death rate (per 1,000 population)		16	11	9	8	6

		About 1980	Most recent
Contraceptive prevalence rate		23	..
(%, 1976)			
Population annual growth rate	Total	3.2	3.9
(%, 1965-1980/1980-1988)	Urban	5.5	5.0

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate		2.9	..
(%, 1965-1980)			
Inflation rate (%, 1965-1980)		16	..
Population in absolute poverty	Urban/rural	../..	../..
(%)			
Household income share	Top 20%/bottom 40%	../..	../..
(%)			
Government expenditure	Health/education	6/21	6/20
(% of total expenditure, 1980/1987)	Defence	16	14
Household expenditure	Health/education	../..	../..
(% of total income)			
Official development assistance:	US$ millions	31	..
(1980/1987)	As % of GNP	..	..
Debt service			
(% of goods & services exports)		..	..

x/ UNICEF estimate.

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

TABLE 1. BREAKDOWN OF ACTUAL EXPENDITURE FOR GENERAL RESOURCES AND SUPPLEMENTARY FUNDING UNDER PREVIOUS CO-OPERATION PERIOD, 1989

(Thousands of United States dollars)

COUNTRY: IRAN (ISLAMIC REPUBLIC OF)
LATEST BOARD APPROVAL: 1989 for 1989-1990
GENERAL RESOURCES: $1,000,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	SF	GR	SF	GR	SF	GR	SF	GR	SF	Total
Health	328		1				3		331		331
Emergency	238	3022				49		20	238	3091	3329
Planning and project support	1		134		3		17		155		155
GRAND TOTAL	567	3022	135		3	49	20	20	725	3091	3816

GR = General resources.
SF = Supplementary funding.

/...

TABLE 2. PLANNED EXPENDITURE FOR GENERAL RESOURCES, NEW SUPPLEMENTARY FUNDING AND FUNDED SUPPLEMENTARY FUNDING

(Thousands of United States dollars)

Country: IRAN (ISLAMIC REPUBLIC OF) Period covered: 1991-1995	Funding status	1991	1992	1993	1994	1995	Total
Health							
Immunization	GR	50	50	50	50	50	250
Control of diarrhoeal diseases	GR	50	50	50	50	50	250
Other health	GR	150	150	150	150	150	750
	NSF	500	500	500	500	500	2500
Subtotal, health	GR	250	250	250	250	250	1250
	NSF	500	500	500	500	500	2500
Nutrition	GR	100	100	100	100	100	500
Advocacy	GR	100	100	100	100	100	500
Planning and project support	GR	50	50	50	50	50	250
TOTAL	GR	500	500	500	500	500	2500
	NSF	500	500	500	500	500	2500
GRAND TOTAL		1000	1000	1000	1000	1000	5000

GR = General resources.
NSF = New supplementary funding.

TABLE 3. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: IRAN (ISLAMIC REPUBLIC OF)	Number of posts	1990-1991 amount (Thousands of US dollars)
FINANCED FROM 1990-1991 APPROVED BUDGET:		
International Professional established posts	1	208
Local national Professional and General Service established posts	4	450
Operating costs		270
Total	5	928
FINANCED FROM PROGRAMME FUNDS: a/		
International Professional project posts		
General resources		
Supplementary funds		
Local national Professional and General Service project posts		
General resources	4	339
Supplementary funds	3	311
Total	7	650

a/ For information source, see 1990 post authorization table, revised October 1989.

Annex

SELECTED LIST OF STUDIES AND EVALUATIONS

1. Diarrhoeal disease control - incidence and treatment, Results of survey, September 1987. Islamic Republic of Iran. Government/UNICEF/WHO.

2. Per cent of diarrhoea cases in 12-23 months children in the last two weeks, Kind of treatment status of continuation of liquids and food. Government/UNICEF/WHO.

3. Knowledge of ORS, source of supply, beliefs in ORS, CDD survey, 1987. Government/UNICEF/WHO.

4. Comparison of KAP of CDD treatment in urban and rural areas, PHC and non-PHC, September 1987. Government/UNICEF/WHO.

5. Water supply, latrines and garbage disposal, CDD survey, September 1987. Government/UNICEF/WHO.

6. Number of reported cases of EPI target diseases (1983-1987) in the Islamic Republic of Iran.

7. Under-one immunization coverage (1984-1987), Ministry of Health and Medical Education/WHO/UNICEF cluster surveys.

8. Neonatal mortality and neonatal tetanus mortality rates in rural and urban areas, 1984-1985. H. Malik Afzali.

9. Tetanus toxoid (TT) immunization of pregnant women in the Islamic republic of Iran, 1983-1987.

10. Percentage of mothers given tetanus toxoid (TT) during pregnancy, Expanded programme of immunization (EPI), cluster surveys (1984-1987). Government/UNICEF/WHO.

11. Maternal and child health care, Results of survey, September 1987. Islamic Republic of Iran. Government/UNICEF/WHO.

12. MCH programme by various indicators for Tehran, urban, PHC and non-PHC areas, Results of survey, September 1987. Government/UNICEF/WHO.

13. MCH performance by various indicators in areas with low, medium and high IMR, Results of survey, September 1987.

14. Child nutrition, Results of survey, September 1987. Islamic Republic of Iran. Government/UNICEF/WHO.

15. Per cent feeding status of under-one children with different kinds of milk. H. Malik Afzali and Shamsa.

16. PHC review with emphasis on EPI/ORT/nutrition/MCH, September 1987. Government/UNICEF/WHO.

17. Evaluation of the cold-chain system in Iran - 1988. Government/UNICEF.

18. The national infant/child mortality cluster survey - April 1989. UNICEF/Government.

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1990 session

FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Iraq

The Executive Director recommends that the Executive Board approve an amount of $2,850,000 from general resources, subject to the availability of funds, and an amount of $2,500,000 in supplementary funds, subject to the availability of specific-purpose contributions, for the country programme of Iraq for the period 1990-1995.

* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme co-operation at the end of 1989, will be contained in the "Summary of 1990 recommendations for general resources and supplementary funding programmes" (E/ICEF/1990/P/L.1).

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THE SITUATION OF CHILDREN AND WOMEN

1. Iraq is a large country, extending 440,000 square kilometres, 60 per cent of which is desert. Administratively, the country is divided into metropolitan Baghdad and 17 governorates which cover 91 districts (qadas), 136 sub-districts (nahias) and about 10,000 dispersed villages and settlements. The population of 18 million is growing at an annual rate of 3.1 per cent, and 73 per cent of the people live in urban areas. There are 3.2 million children under the age of five years and 3.2 million women of child-bearing age.

2. Despite its large resource base, the economy of Iraq was adversely affected by the eight years of war, particularly by heavy defence spending and a sharp reduction in oil prices and revenues. The gross domestic product (GDP) has declined from an annual average of 19 per cent in the 1970s to a negative growth of 16 per cent between 1983 and 1987. Since the cease-fire in 1988, a rise in GDP of 1.7 per cent has been reported.

3. The upward trend in consumer prices has led to an estimated 40 per cent annual inflation rate (1987-1988), affecting basic commodity items and creating continuous pressure on large families with moderate and low incomes. The Government is subsidizing food, clothing and housing, in addition to controlling consumer prices.

4. To address the economic recession, the Government has made economic and structural adjustment policies and has reorganized State-run institutions for increased efficiency in decision-making and implementation. The economic reforms stress improvement in agricultural and industrial production and stimulate the private sector to export national products. Incentives are being offered to farmers in order to discourage the rural exodus, and to workers in the form of bonuses and profit-sharing.

5. The establishment of the Arab Co-operation Council by Egypt, Iraq, Jordan and Yemen on 16 February 1989 was a significant political development aimed at co-operation and co-ordination to enhance socio-economic development.

6. Women occupy 29 out of 250 seats in the National Assembly, the highest legislative decision-making body in the country. The number of economically active women has risen sharply from 17 per cent in 1982 to 35 per cent in 1986; 35 per cent of these are involved in agriculture, 28 per cent in industry and 17 per cent in social services. During the war, and in the absence of the male heads of household, women assumed non-traditional roles as bread-winners and decision-makers, and this has resulted in a rapid socio-cultural transformation in Iraqi society.

7. To facilitate women's participation in national development, the Government has passed laws providing them with equal opportunities in education, health, employment, land ownership, cultivation and bonuses. Working mothers have the right to take six months of maternity leave with full salary, plus six months at half salary, and can retire at 55 years of age. The majority of working women, however, have little access to day-care services, and low coverage and inadequate knowledge about early child stimulation and development are continuing concerns.

8. Infant and child mortality rates have declined sharply in the last few decades. National cluster surveys by the Ministry of Health in 1985 and 1988 show a decline in the infant mortality rate (IMR) from 65 to 47 per 1,000 live births, although a significant disparity was found among the governorates. In rural areas, IMR declined from 84 to 59 per 1,000 live births, compared to an urban IMR decline from 46 to 41 per 1,000 live births. However, the United Nations Population Division estimates IMR in 1988 at 68 per 1,000 live births and the under-five mortality rate (U5MR) at 94 per 1,000 live births for 1988.

9. Factors associated with infant and child mortality are mainly diarrhoeal diseases, acute respiratory infections (ARI), vaccine-preventable diseases and accidents. According to the 1987 national cluster survey, neonatal tetanus, prematurity, low birth weight and birth-related complications accounted for 28 per cent of total infant deaths and 20 per cent of under-five deaths.

10. The maternal mortality rate as reported by the Ministry of Health was 114 per 100,000 live births in 1982. This is directly associated with low coverage of antenatal, natal and post-natal services; the failure of early detection; low referral of at-risk pregnant women; lack of mothers' knowledge of child-bearing practices; and the large number of home deliveries (at least 50 per cent) performed by untrained traditional birth attendants (TBAs).

11. The nutritional status of children has improved greatly during the last two decades owing to socio-economic development and the expansion of basic services. However, anaemia and vitamin and iodine deficencies are still prevalent, particularly in the northern rural areas. Breast-feeding, as indicated by the 1985 national cluster survey, is declining. Despite generous maternity leave and time allowed on the job for mothers to breast-feed their babies, only 76 per cent are breast-fed for three months, 43 per cent for six months, and 25 per cent for a full 12 months. Growth monitoring is a routine maternal and child health (MCH) service, but the growth charts could be better used as an educational tool.

12. Although intensive efforts have been directed towards improving and expanding access to water supply, only 54 per cent of the rural population benefit, compared to 100 per cent of the urban population. Sanitation remains more problematic, although there are ambitious plans to build a modern sewage network. New technology is needed to address the problem of high water tables, thereby preventing contamination. Better community awareness and mobilization are needed at the community level to develop appropriate hygienic practices and sanitation.

13. Childhood disability is emerging as a national priority after the war, although information on its extent and causes is sparse. In 1980, legislation was introduced to provide for the rehabilitation and integration of the disabled into society. Aside from war-related delays in programme implementation, the Government's approach has been institutional, with little emphasis on social integration and prevention.

14. The nation-wide network of health centres and mobile teams provide urban and rural populations with free basic health services, including preventive care. However, the heavy reliance on curative services places a heavy burden on scarce medical resources.

15. High literacy rates in Iraq are attributed to the extensive adult education campaign of 1978-1987. The Ministry of Education reported that about 87 per cent of adult females (15-45 years of age) and 90 per cent of adult males were literate. Primary education is compulsory and free for both sexes. School enrolment in 1988 was 91 per cent for boys and 82 per cent for girls. The primary education network extends to the most remote areas, with 7,930 primary schools, 122,089 teachers and about 3 million students (6-12 years of age) in 1988.

16. This stable and extended teaching force could be used as a strategic channel to instil healthy living practices in children and parents. However, the drop-out rate increases constantly through primary school, reaching 32 per cent for boys and 42 per cent for girls after six grades. Cultural factors, such as early marriages and the confinement of girls to the home, contribute to the disparity in enrolment and drop-out rates, particularly in rural areas.

17. With regard to social mobilization, easy access to the grass-roots level through community-based activities is an important feature. Mass organizations can reach every household through face-to-face contact and education. These organizations include the General Federation of Iraqi Women (GFIW), the Farmers', Labour and Youth Unions, People's Councils and a powerful political party. The press has wide circulation and the mass media, particularly television and radio, reach 90 per cent of the population.

PROGRAMME CO-OPERATION, 1988-1989

18. UNICEF co-operation for 1988-1989 aimed principally at strengthening nation-wide primary health care (PHC) services. Following the cease-fire in August 1988, UNICEF became involved in a major programme of rehabilitation of the PHC network in the seven war-affected provinces. The universal child immunization target will be achieved and a new pattern for improving MCH, especially in rural areas, has emerged from the model MCH/PHC Mahmoudiya/Babylon experience. Upgrading the birth practices of TBAs and the health education of mothers has helped to save the lives of thousands of neonates and infants. Furthermore, during this period, 31,000 community motivators and 30,000 primary school teachers, supported by 50 television and 150 radio spots, have raised the child survival and development (CSD) awareness of 3 million mothers and children.

Maternal and child health

19. Despite the country's difficult circumstances, substantial progress has been made in MCH care in line with the country's five-year plan (1985-1990). MCH was integrated into all health services with an emphasis on antenatal, natal and post-natal care; the promotion of breast-feeding; the use of growth charts; at-risk screening and referral systems; improving the information, recording and reporting system; and upgrading TBA practices.

20. The urban TBA training project initiated in 1984, followed by the training of about 50 unlicensed and untrained rural TBAs in Mahmoudiya district, was evaluated and revised in 1988. It was extended to the remaining four districts in the

Babylon governorate for the training of 100 TBA trainers, 1,000 urban TBAs and 400 rural TBAs by the end of 1989. This project has contributed greatly to medical recognition of the role of TBAs in reducing neonatal and infant mortality.

21. The project recorded increases in the utilization of MCH services and an acceleration in immunization coverage and the use of oral rehydration therapy (ORT). However, the goals for at-risk children and mothers have not been reached. The district MCH approach and TBA training need further strengthening and expansion in other governorates. The management capacities of MCH services at national, sub-national and peripheral levels also require further reinforcement.

22. UNICEF support included advisory services for training MCH physicians, managers, TBAs and information recording staff in management, evaluation and the at-risk approach. UNICEF also provided midwifery kits, scales for growth monitoring, TBA training manuals and educational and media material.

Expanded programme on immunization

23. From 1980 to 1987, the incidence of vaccine-preventable diseases declined tremendously, while immunization coverage increased. The Ministry of Health reports the following reductions in mortality: from 28 to 6 deaths for diphtheria; from 58 to 0 for pertussis; from 75 to 2 for polio; from 68 to 6 for measles; from 150 to 49 for tuberculosis; and from 589 to 112 for neonatal tetanus. The extended programme on immunization (EPI) campaign, initiated in 1985 and followed by three rounds of annual acceleration days until 1988, has contributed extensively to the increase in coverage. The 1985 and 1989 cluster surveys revealed the following increases in coverage: from 82 to 86 per cent for anti-tuberculosis vaccine (BCG); from 74 to 86 per cent for three doses of combined diphtheria/pertussis/tetanus and the oral polio vaccine; from 22 to 78 per cent for measles vaccine; and from 9 to 66 per cent for two doses of tetanus toxoid (TT2) to pregnant women. However, some of the governorates have low coverage rates, particularly with measles and TT2, and need special attention, particularly in rural and remote areas.

24. Social mobilization and health education have been the most effective programme elements for sustaining and expanding the demand for immunization. An early 1989 knowledge, attitude and practice (KAP) survey found that 90 per cent of mothers were aware of the importance of vaccines from television and personal contacts by community health motivators. Birth certificates began to be issued exclusively on BCG vaccination cards. GFIW community health motivators then followed up to ensure that children were fully vaccinated against diphtheria, pertussis, tetanus, polio, measles and tuberculosis.

25. UNICEF assistance included support for EPI registration and disease surveillance, cold-chain operations, coverage surveys and the training of 60 EPI managers, who in turn trained 100 health workers and 1,000 community motivators, primary school educational supervisors and information managers at national and sub-national levels. In addition, UNICEF provided vaccines, cold-chain supplies and equipment, and transport for supervision to central level managers and produced EPI manuals, teaching and educational aids, 20,000 posters and 50,000 fact sheets on immunization which were disseminated to PHC workers, community motivators, mothers and schoolchildren.

Control of diarrhoeal diseases

26. As part of the five-year plan for child survival, the control of diarrhoeal diseases (CDD) programme initiated in 1985 has had a tremendous impact on the prevention of dehydration and associated mortality among infants and children under five years of age. National surveys in 1985 and 1987 showed a drop in diarrhoea episodes from four to two per child per year and a decline in associated mortality from 8.5 to 1.7 per 1,000 children. The drop in diarrhoea episodes is attributed to the establishment of ORT centres in all health facilities, especially rural areas; the provision of enough oral rehydration salts (ORS) packets free of charge to all communities; and the ORT training of 90 per cent of medical staff, paramedicals, primary school teachers and community health motivators. ORT was promoted through national symposia, seminars and the media, as well as through daily personal contact by 31,000 community health motivators and 3,000 primary school teachers, even in the most remote communities.

27. Another major activity was the training of health providers. After 16 senior-level managers reported favourably on their study tours to Egypt in 1988, more orientation visits were organized for 30 mid-level CDD manager's from central and governorate levels. They, in turn, trained 100 MCH physicians and some 3,000 health staff and community workers. In addition, on-site orientation was organized for 200 paediatricians and 3,000 pharmacists through travelling seminars conducted by a team composed of paediatric and pharmaceutical societies, the CDD programme manager and UNICEF staff.

28. The production of ORS, started in 1985, reached 15 million sachets in 1988. The plan to produce it with trisodium citrate, according to the World Health Organization (WHO)/UNICEF formula, has been postponed until the existing stock of printed aluminium foil is exhausted.

29. Physicians continue to prescribe anti-diarrhoeal drugs in 62 per cent of diarrhoea cases in spite of the ban on importing these drugs. A committee from the Ministry of Health and the medical syndicate check randomly on medical professionals, who are liable to questioning and warning if found guilty. The ban needs continued follow-up. CDD activities also need to be integrated with EPI and MCH services to sustain and strengthen programme impact and to improve the sentinel surveillance and reporting systems, while decreasing the load on medical staff.

Social mobilization and advocacy

30. In support of communication activities, various training seminars, workshops, meetings, television panels and technical group discussions were organized in collaboration with the Ministry of Health, professional societies, schools of medicine, GFIW, the media and UNICEF. CSD communication messages included 20,000 manuals to physicians, pharmacists and community motivators; 50,000 posters; 1,000 flip charts; 500,000 fact sheets; 50 television spots; and 100 radio spots. These were all designed, tested and produced with UNICEF collaboration.

31. The national network of GFIW has a cadre of supervisory/training teams composed of two health motivators and a driver and reaching all the governorates, districts and village levels. Each team is assigned 24 villages to be visited once

a month. At the village level, the liaison officer provides health education, assesses the health situation of mothers and children, makes referrals to health centres, registers new deliveries, checks on vaccination cards and is considered the community's first health contact. This has played a big role in social mobilization. In November 1989, 134 rural teams were serving 3,216 villages, and more teams are being established in the northern Kurdish area.

Early childhood development

32. Day-care services and kindergartens were evaluated with UNICEF assistance in 1984. A United Nations Development Programme (UNDP)/UNICEF project subsequently established a teacher-training centre in collaboration with the Ministry of Labour and Social Affairs. A core team of eight teachers, trained in the United States of America, has trained 24 national teachers thus far.

33. Given the increase of women in the labour force, a joint pilot project with GFIW was also carried out in three selected communities to develop a model of community-based day care aimed at making day care more accessible and less costly to working mothers. The caregiver, a mother accepted by the community, provided day care in her home for five to six children from the neighbourhood. She was trained on the stimulation, educational and nutritional needs of children and was given a financial incentive equivalent to $1,500 from the co-operatives. Supervision of performance and follow-up is done by GFIW.

Rehabilitation of the primary health care network (Operation Peace for Children)

34. After the cease-fire, UNICEF supported a return to "normalcy" in the seven war-torn provinces by launching an emergency relief programme to rehabilitate and reactivate the PHC network. Estimates indicated that 30 per cent of the facilities in those provinces had been completely demolished, 30 per cent had become unusable and the rest had been affected either partially or indirectly. The health staff had been depleted by army recruitment and not replaced. The network thus needed to be rebuilt to provide PHC services to 5 million people.

35. UNICEF support included the distribution of supplies and equipment to 160 health centres and 150 subcentres, training material and audio-visual aids for 12 multi-purpose training centres, 800 TBA kits, 200 vehicles, monitoring and training. UNICEF will continue to support the strengthening of the PHC network, to assist in meeting health manpower training needs through refresher courses and to encourage GFIW efforts in social mobilization through the development of communication materials.

Monitoring and evaluation

36. Most services and reports over the past few years experienced gaps in the information base that adversely affected planning for CSD. To address this situation, a child and women monitoring and information unit at the National Bureau of Statistics of the Ministry of Planning was established, and a director with a data management team was appointed. UNICEF provided supplies and assistance for a review of the existing data management system and recommended courses of action.

Lessons learned

37. Despite adverse circumstances in the past few decades, CSD has become an important advocacy and mobilization theme of grass-roots organizations. UNICEF collaboration with the GFIW network was one of the most fruitful experiences.

38. As the EPI programme approaches universal coverage, it faces the challenges of sustaining and increasing public knowledge of the vaccination calendar; ensuring vaccine accessibility; improving EPI registration; keeping records of disease surveillance and epidemiological investigations; and maintaining vaccine quality control.

39. Inconsistent and unreliable data with unclear impact indicators continue to undermine effective programming. Considerable support is still needed to enable the monitoring unit in the Ministry of Planning to produce reliable data necessary for long-term planning.

RECOMMENDED PROGRAMME CO-OPERATION, 1990-1995

Recommended general resources: $2,850,000
Supplementary funding: $2,500,000

Recommended programme co-operation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health	1 630	1 200	2 830
Early childhood development	225	400	625
Social mobilization/advocacy	655	400	1 055
Planning/statistics	340	500	840
Total	2 850	2 500	5 350

a/ The breakdown for estimated yearly expenditures is given in table 2.

b/ In addition, there are also funded supplementary funding projects shown in table 2.

40. In 1989, the President publicly committed Iraq to "lowering IMR enough to be compared to developed countries". This high-level commitment has mobilized all government sectors towards achievement of that goal. The recommended programme co-operation takes into account the national development policies and priority problems identified in the situation analysis, UNICEF policies, the medium-term plan, global strategies for children in the 1990s and lessons learned from previous co-operation between Iraq and UNICEF.

41. The Government of Iraq and UNICEF have developed a plan of operations for 1990 to mid-1995 covering four major programmes: health; early childhood development; social mobilization/advocacy; and planning/social statistics. UNICEF will support government plans to advocate the well-being and development of children and women as national priorities in development planning and to improve the status and welfare of children and women and provide greater opportunities for them to achieve their full potential, growth and development.

42. The programme will continue to focus on rural and remote areas to address the geographic disparity of children's problems and services in Iraq. The PHC policy and child survival strategy will continue to be emphasized.

43. The health programme will encompass five projects. MCH, EPI and CDD projects will be continued, and an ARI control project will be introduced, as well as a childhood disability project to address the prevention, early detection and rehabilitation of disabled children.

44. The early childhood development programme will focus on community-based day-care services to benefit the child and to enhance opportunities for the mother's advancement and participation in the labour force. The social mobilization/advocacy programme aims to increase the participation of non-health sector resources to realize better co-ordination and outreach of services. Health education will be further emphasized as the backbone of all programme activities to create awareness, develop healthy living practices and ensure active participation through the dissemination of information, education and mass communication. The planning/social statistics programme makes child monitoring and evaluation an integral component of UNICEF assistance, providing the means for advocacy and assessment of programme impact.

45. Special advocacy efforts will be made to build and reinforce alliances with professional institutions and the media to raise awareness of children's rights and to influence programmes and services benefiting children and women. The themes of adjustment with a human face, nutrition, girls' education, women's development, safe motherhood, water and sanitation and healthy living practices will also be emphasized.

Health

Maternal and child health

46. The objective is to develop and expand MCH services to cover 75 per cent of mothers and children, particularly in rural areas. The development and expansion of MCH services at all levels will build on the district health approach, with high-risk assessment and growth monitoring as corner-stones. A referral system will be further developed to better manage problems such as complicated deliveries, prematurity and low-birth-weight babies.

47. The TBA training project will be replicated in more than 91 districts throughout the country to ensure that at least 70 per cent of pregnant women know about basic child-bearing practices. By mid-1995, some 400 trainers and 4,000 TBAs

will be trained. Community leaders, GFIW and the Farmers' Union will be mobilized to recruit TBAs, provide transport for training and meetings and report on TBA performance.

48. Pre-service and in-service training will also be provided to the Ministry of Health/PHC personnel. Courses will be organized by the multi-purpose demonstration and training centres in each governorate, with technical back-up from existing expertise in academic and research institutions, as well as professional organizations. International experts will provide further support in reorienting medical curricula to MCH/PHC and directing medical education towards community health.

49. The expansion of MCH/PHC services will be matched by social mobilization and community participation directed towards vulnerable mothers and children. Existing MCH/PHC councils, composed of various sectors and non-governmental organizations (NGOs) at central and local levels, will be reactivated and mobilized to participate in the assessment of local needs and to carry out community-based activities. Mobilization will aim at strengthening the momentum and enthusiasm of previous achievements.

50. Facts for Life will be used in this context to impart information about preventive measures, safe birth awareness, the use of health services and improving hygiene and domiciliary sanitary practices to educators and mothers.

51. The establishment of a monitoring system will be central to the MCH project. Surveys, studies and research will be planned to identify the causes, frequency and distribution of specific problems such as child and maternal mortality, the prevalence of anaemia, low birth weight and prematurity so as to direct future actions and measure progress.

52. UNICEF will provide technical and training support to the MCH/PHC network, as well as midwifery kits, weighing scales for growth monitoring, ferrous sulphate to control anaemia, teaching aids, communication materials and basic supplies.

Expanded programme on immunization

53. The major objective is to further reduce morbidity and mortality due to vaccine-preventable diseases. The project will focus on sustaining the following levels of immunization coverage achieved in the previous cycle: 90 per cent coverage of children under one year of age against each of the six immunizable diseases; and 90 per cent of pregnant women and 80 per cent of women (15-45 years old) with five doses of tetanus toxoid. The national goal is to eradicate poliomyelitis; eliminate neonatal tetanus; reduce the number of deaths resulting from measles by 90 per cent; and reduce the number of measles cases by 95 per cent.

54. This project will focus on the governorates that are lagging behind in measles and tetanus toxoid vaccination coverage. Results from the 1989 national health survey revealed that low coverage rates were mainly in the seven war-affected governorates. Priority will also be given to integrating EPI, MCH and CDD services; maintaining the quality of the cold chain and vaccines from central to

rural health units; improving EPI reporting and surveillance systems for identifying drop-outs; reinforcing public awareness; and instituting a system for destroying syringes and needles.

55. To help sustain the effectiveness of EPI service delivery, UNICEF will support the execution of surveys, studies and evaluations; train trainers and health teams; revise curricula of medical and nursing education; strengthen information management systems at all levels; and maintain the quality of the cold chain. In addition, social mobilization and health education will also be targeted to non-health sectors by utilizing female rural motivators to sustain public awareness and to integrate messages related to other CSD activities.

Control of diarrhoeal diseases

56. This project aims to reduce child mortality associated with diarrhoeal dehydration from 1.7 to 1 per 1,000 children and to increase the use of ORT from 74 to 90 per cent of child dehydration cases. The strategies to be addressed include the integration of CDD activities in all PHC networks and community-based services; regular ORT training for health personnel, TBAs, community health motivators and primary school teachers; enhancement of social mobilization and communication to ensure a widespread use of ORS in the treatment of child dehydration; the promotion of breast-feeding, appropriate weaning, potable drinking water, proper sanitation and food safety practices; and the improvement of monitoring and surveillance of diarrhoea-associated morbidity and mortality in children.

57. With UNICEF support, the curricula of medical, pharmaceutical and paramedical schools will be revised to integrate the principles of prevention and treatment of diarrhoeal dehydration. Refresher courses in EPI and CDD will be held in 1990 and 1991 for 80 paediatricians and 80 technical supervisors. The 800 ORT demonstration units established in health facilities will be used for the practical training of health workers, community health motivators and mothers to raise awareness about ORT practices. Mothers also will be advised on breast-feeding, the use of clean water, personal hygiene, sanitary conditions and appropriate weaning practices, and they will be encouraged to continue the feeding of their children during bouts of diarrhoea. The Government is working to ensure access to potable water in rural areas.

58. In support of the national ban on anti-diarrhoeal drugs, UNICEF will maintain close follow-up with the Ministry of Health to ensure its enforcement in diarrhoea treatment. In addition, UNICEF will provide technical support to monitor and assess programme impact on diarrhoea morbidity and mortality, as well as to develop and disseminate educational material on the proper use of ORT through other sectors and NGOs.

Acute respiratory infections

59. Based on a survey carried out in the Basra governorate in 1982, ARI was identified as the leading cause of IMR, accounting for nearly 40 per cent of total infant deaths. The disease is believed to be most common in mountainous areas, especially in the winter.

60. The project objective is to reduce U5MR due to ARI by 25 per cent from the 1990 planned survey findings through preventive measures and early diagnosis and treatment. This will be achieved by creating awareness among 80 per cent of mothers about prevention and early detection of ARI, training 90 per cent of health staff in case management of the disease, ensuring careful hospital screening and developing a surveillance and evaluation system to monitor ARI morbidity and mortality.

61. A survey will initially assess the magnitude and causes of ARI, groups at risk and current treatment practices. Based on the survey results, strategies will be developed for ARI prevention, including WHO standardized case-management protocols, adaptable to all levels from community-based services to the referral hospital. Training materials and teaching aids will be developed for various categories of health personnel. The experience of personal communication gained from the EPI/CDD programmes will be used in raising mothers' awareness about ARI through teachers and TBAs trained to identify ARI signs and symptoms, disease severity, case management and referral system.

62. Sentinel sites will be established under the MCH programme for monitoring the incidence and mortality from EPI diseases, ARI and diarrhoeal diseases. The Government will provide an adequate supply of drugs and low-cost antibiotics to health facilities with clear instructions on their utilization. A nation-wide communication programme will be carefully planned to draw the attention and compliance of health workers and mothers.

63. UNICEF support will be provided to organize and undertake surveys, as well as research, training materials, social mobilization, monitoring, evaluation and supervision. ARI will be integrated with other MCH/PHC activities.

Childhood disability

64. In order to prevent and reduce the incidence of childhood disability and advocate social integration of disabled children over the next five years, a survey will be conducted to assess the magnitude of disability, cause distribution and current services provided. Childhood disability issues will be incorporated into health, nutrition, education and social welfare programmes. Technical support will be provided through consultations, case studies and experimental projects. Emphasis will also be placed on capacity-building activities for national planners, administrators, professionals, supervisors and community workers. Current supervisors active in the field of childhood disabilities will be trained to train others on prevention, early detection and rehabilitation of the disabled. Experiences of other agencies, such as the International Labour Organisation (ILO), UNDP and the United Nations Educational, Scientific and Cultural Organization (UNESCO) will be drawn upon, especially in developing an adequate monitoring and evaluation system.

65. An important element of the project is to raise public awareness about the causes and prevention of disabilities. Communication materials will be designed for regular dissemination through the mass media and community-based resources. UNICEF will provide support through consultancies, training, surveys and studies

and evaluations, as well as the development and production of communication and teaching materials.

Early childhood development

66. This programme seeks to promote and expand early childhood development through extension of the network of day-care services to children of working mothers by establishing 100 in-home day-care facilities supported by the communities. This will encourage the participation of women in national socio-economic development, while stimulating and developing creative thinking in pre-schoolers.

67. The current UNDP/UNICEF project to establish a day-care training centre will be evaluated to assess progress, social impact and areas requiring further action. In-service training of day-care centre staff will continue through UNDP, and two new centres will be established (one in the north and another in the south) to decentralize training. Appropriate teaching aids will be designed and produced for use in training programmes and to develop child learning ability.

68. As a part of the Ministry of Health's child survival plan, Facts for Life will be introduced to mothers through the day-care services. UNICEF will support the planning and organization of the teaching sessions. A national symposium will be organized to discuss priority needs of Iraqi children in their pre-school growth and development and to identify strategies for meeting them. In collaboration with universities and research institutions, an information system will be established to guide day-care service planning. The day-care project will be evaluated at two-year intervals to assess progress and identify areas for improvement.

69. UNICEF technical assistance will support the design and evaluation of training courses for teachers and caregivers, educational and stimulative programmes for children and the development of teaching aids and communication materials. Support will also be provided to strengthen the monitoring, evaluation and community education activities.

Social mobilization/advocacy

70. A strategic component of programme co-operation will continue to be a social information management system to ensure reliable and valid baseline data for effective planning and programming for children and women. This component will advocate the well-being and development of children and women as a priority in national planning and ensure sustainability of CSD achievements. Formal and informal means of communication will use Facts for Life as the basis for public awareness and community mobilization in support of CSD programmes. Social mobilization skills of health personnel, community health motivators, TBAs and primary school teachers will be reinforced through training.

71. Mobilization and health education activities need to be synchronized to avoid duplication of efforts. Top priority will be given to establishing a co-ordinating unit with access to technical and managerial resources in the mass media. UNICEF will assist the development of planning capacities as well as the design and production of effective audio-visual materials.

72. Advocacy will continue on behalf of policies regarding the importation of powdered milk, the rights of children, girls' education and adjustment with a human face. Breast-feeding, which is on the decline, will be promoted by building on the UNICEF/WHO Joint Declaration on Infant Feeding Practices and existing legislation related to maternity leave and time off from work for mothers to breast-feed their babies. In nutrition, the advocacy will focus on the utilization of available food resources for a balanced diet, stressing measures to combat anaemia. UNICEF will collaborate with other United Nations agencies that are active in the nutrition field.

73. Facts for Life will be the basis of communication activities directed towards decision makers, programme managers, health providers, teachers, educators, the media, religious groups, women's organizations, community workers and motivators, as well as parents and children. Multisectoral activities will be planned and implemented to include the ministries of Health, Education, Culture and Information, Labour and Social Affairs, as well as NGOs, such as GFIW, the unions, the People's Councils and related professional organizations. This will build stronger alliances for promoting the Iraqi child, while also developing their own communication skills.

74. UNICEF will provide technical support, training grants and study tours and will assist in the design and production of teaching and communication materials, KAP studies and evaluations, national seminars for advocacy of policies and adoption of programmes benefiting children and mothers.

Planning and social statistics

75. Establishing a reliable data system on the status of women and children is a priority for monitoring social development and long-term planning. Existing data systems and sources in various social sectors will be reviewed to assess coverage, methods of reporting and analysis and use of data. The support of UNICEF, WHO, the Economic and Social Commission for Western Asia (ESCWA) and other United Nations agencies is solicited for this. A series of CSD indicators will consequently be developed as a composite tool for measuring the progress and impact of activities. UNICEF support will be provided to strengthen the child and women's information monitoring unit at the Bureau of Statistics of the Ministry of Planning. This will include study tours and training on computerization of information for rapid data analysis and reporting. Technical advice will be sought to design a mechanism to enable the child monitoring unit to co-ordinate the activities of sentinel and surveillance centres affiliated with the EPI/CDD/MCH programmes. Technical advice will also be sought to design a system to collect, analyse and disseminate reliable data on the progress and impact of CSD activities. The collaboration of universities and research institutions will be sought for studies and household surveys on the impact of economic adjustment and other specific child problems such as disability, low birth weight, malnutrition, prematurity and iodine deficiency.

76. A symposium will be convened to review and integrate the statistical data on CSD and to suggest necessary action through the collaboration of decision-makers and professionals from social sectors and NGOs. UNICEF and WHO will collaborate in the preparation of the symposium and participation in it.

Co-operation with other United Nations agencies and bilateral organizations

77. The cordial relations that exist between UNICEF and other United Nations agencies in Iraq have facilitated the development of the programme of co-operation. Specific areas of co-operation will be with WHO and the Government of Iraq in implementing the MCH, EPI, ORT and ARI projects. UNICEF will co-operate with UNDP in evaluating the day-care project. Co-operation will also be maintained with ESCWA, tapping its technical expertise in household survey designs, data collection, analysis and interpretation related to infant and child mortality and establishing a data-base system, as well as studies related to development, particularly the development of women. UNICEF will continue to maintain bilateral relations with regular meetings for information sharing, experience exchange and advocacy of UNICEF strategies for children.

IRAQ

Basic data: 1988 and earlier years			UNICEF country classification
Under-five mortality rate	94	(1988)	Middle U5MR
Infant mortality rate	68	(1988)	Middle IMR
GNP per capita	$3,020	(1980)	Upper-middle GNP
Total population	18 million	(1988)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1988
Births	(thousands)	453	608	695	751
Infant deaths (under 1)	(thousands)	47	49	51	51
Under-five deaths	(thousands)	65	67	70	71
Under-five mortality rate (per 1,000 live births)		143	110	101	94
Infant mortality rate (under 1) (per 1,000 live births)		103	80	73	68

		About 1980	Most recent
Underweight children (under 5) (% weight for age)	Moderate & severe	..	..
	Severe	..	..
Babies with low birth weight (%, 1979/1985)		6	9*
Children completing primary level (% of first grade, 1986)		..	71

NUTRITION INDICATORS		About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1983)		../../..	76/45/19
Prevalence of wasting (%, 1985)		..	2
Prevalence of stunting (%, 1985)		..	14
Daily per capita calorie supply (% of requirements, 1979-1981/1984-1986)		114	124
Food production per capita index (Index 1979-81=100, 1980/1988)		99	102
Household expenditure (% of total income)	All food/cereals	../..	../..

HEALTH INDICATORS		About 1980	Most recent
ORS use rate (%, 1986-87)			44
Access to health services	Total	..	93*
(% of population, 1986)	Urban/rural	../..	97*/78*
Access to safe water	Total	73*	87
(% of population, 1980/1986)	Urban/rural	97*/22*	100/54
Access to adequate sanitation	Total	..	75
(% of population, 1986)	Urban/rural	../..	100/11
Births attended by trained personnel (%, 1987)		..	50*
Maternal mortality rate (per 100,000 live births, 1985)		..	12*

Immunization		1981	1985	1987	1988
One-year-olds (%) immunized against:	Tuberculosis	76	82	99	87
	DPT	13	74	76	86
	Polio	16	74	76	86
	Measles	33	22	69	78
Pregnant women (%) immunized against	Tetanus	4	9	53	56

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IRAQ

Basic data: 1988 and earlier years			UNICEF country classification
Under-five mortality rate	94	(1988)	Middle U5MR
Infant mortality rate	68	(1988)	Middle IMR
GNP per capita	$3,020	(1980)	Upper-middle GNP

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net)	Total	115/98	98/86
(%, 1980/1987)	Male	120/100	105/91
	Female	109/95	91/82
Secondary enrolment ratio (gross/net)	Total	57/47	49/50
(%, 1980/1987)	Male	75/62	60/50
	Female	38/31	38/31
Adult literacy rate, 15 years & older	Total	34	89
(%, 1970/1985)	Male/female	50/18	90/87
Radio/television sets			
(per 1,000 population, 1980/1987)		158/49	199/64

DEMOGRAPHIC INDICATORS		1970	1980	1985	1988	2000**
Total population	(millions)	9.4	13.3	15.9	17.7	26.3
Population aged 0-15 years	(millions)	..	6.5	7.8	8.7	
Population aged 0-4 years	(millions)	..	2.6	3.0	3.2	4.4
Urban population (% of total)		56	66	71	73	79
Life expectancy at birth (years)	Total	71	73	74	74	76
	Male/female	55/56	61/63	62/64	63/65	67/71
Total fertility rate		7.1	6.8	6.5	6.3	5.2
Crude birth rate (per 1,000 population)		48	46	44	42	37
Crude death rate (per 1,000 population)		16	9	8	8	5

		About 1980	Most recent
Contraceptive prevalence rate		14	..
(%, 1974)			
Population annual growth rate	Total	3.4	3.5
(%, 1965-1980/1980-1987)	Urban	5.3	4.8

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate		..	0.5*
(%, 1965-1980/1980-1987)			
Inflation rate (%)		..	..
Population in absolute poverty	Urban/rural	../..	../..
(%, 1977/1988)			
Household income share	Top 20%/bottom 40%	../..	../..
(%, 1977)			
Government expenditure	Health/education	5*/3*	../..
(% of total expenditure, 1981)	Defence	24*	..
Household expenditure	Health/education	2*/1*	2*/1*
(% of total income, 1979/1987)			
Official development assistance:	US$ millions	9	91
(1980/1987)	As % of GNP	..	..
Debt service		..	..
(% of goods & services exports)			

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

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TABLE 1. BREAKDOWN OF ACTUAL EXPENDITURE FOR GENERAL RESOURCES AND SUPPLEMENTARY FUNDING UNDER PREVIOUS CO-OPERATION PERIOD, 1988-1989

(Thousands of United States dollars)

COUNTRY: IRAQ
LATEST BOARD APPROVAL: 1988
GENERAL RESOURCES: $600,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	SF	GR	SF	GR	SF	GR	SF	GR	SF	Total
Health	198		67				198		463		463
Community organization and development	8		36				12		55		55
Emergency	496	2795		23		78		101	496	2997	3493
Planning and project support	21		25		55		48		149		149
Freight	12								12		12
GRAND TOTAL	736	2795	128	23	55	78	258	101	1177	2997	4174

GR = General resources.
SF = Supplementary funding.

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TABLE 2. PLANNED EXPENDITURE FOR GENERAL RESOURCES, NEW SUPPLEMENTARY FUNDING AND FUNDED SUPPLEMENTARY FUNDING

(Thousands of United States dollars)

Country: IRAQ Period covered: 1990-1995	Funding status	1990	1991	1992	1993	1994	1995	Total
Health								
Immunization	GR	30	30	30	30	30	20	170
	NSF		20	20	20	20	20	100
Control of diarrhoeal diseases	GR	45	45	45	45	45	40	265
	NSF		30	30	30	30	30	150
Other health	GR	210	210	210	210	210	145	1195
	FSF	200						200
	NSF		190	190	190	190	190	950
Subtotal, health	GR	285	285	285	285	285	205	1630
	FSF	200						200
	NSF		240	240	240	240	240	1200
Social mobilization and advocacy	GR	115	115	115	115	115	80	655
	FSF	200						200
	NSF		80	80	80	80	80	400
Early childhood development	GR	40	40	40	40	40	25	225
	NSF		80	80	80	80	80	400
Planning and social statistics	GR	60	60	60	60	60	40	340
	NSF		100	100	100	100	100	500
TOTAL	GR	500 a/	500	500	500	500	350	2850
	FSF	400						400
	NSF		500	500	500	500	500	2500
GRAND TOTAL		900	1000	1000	1000	1000	850	5750

GR = General resources.
NSF = New supplementary funding.
FSF = Funded supplementary funding.

a/ In addition, $450,000 was allocated for unfunded supplementary funding (E/ICEF/1988/P/L.28).

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TABLE 3. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: IRAQ	Number of posts	1990-1991 amount (Thousands of US dollars)
FINANCED FROM 1990-1991 APPROVED BUDGET:		
International Professional established posts	1	242
Local national Professional and General Service established posts	4	636
Operating costs		354
Total	5	1231
FINANCED FROM PROGRAMME FUNDS: a/		
International Professional project posts		
General resources		
Supplementary funds	1	175
Local national Professional and General Service project posts		
General resources		
Supplementary funds	3	245
Total	4	420

a/ For information source, see 1990 post authorization table, revised October 1989.